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BUDGET RECONCILIATION

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

SEPTEMBER 11, 12 and 13, 1985

Printed for the use of the Committee on Finance

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BUDGET RECONCILIATION

WEDNESDAY, SEPTEMBER 11, 1985

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Robert Packwood (chairman) presiding.

Present: Senators Packwood, Durenberger, Symms, Grassley, Long, Bentsen, Moynihan, Baucus, Bradley, and Mitchell.

[The press release announcing the hearing, summary of deficit reduction by the Joint Committee on Taxation, the prepared written statements of Senators Bob Dole, Dave Durenberger, and Pete Wilson follow:]

[Press release No. 85-067, Aug. 9 1985]

SENATE FINANCE COMMITTEE TO BEGIN WORK ON DEFICIT REDUCTION IN EARLY SEPTEMBER

The Senate Finance Committee will hold hearings on deficit reduction on Wednesday, September 11, on Thursday, September 12 and on Friday, September 13, Committee Chairman Bob Packwood (R-Oregon) announced today.

"No problem facing this country is more compelling than our growing Federal budget deficit—action must be taken by Congress now if we are to avert serious economic consequences," Senator Packwood said. "I am convinced that a significant reduction in the deficit will be a boon to the economy, resulting in lower interest rates, more capital available for private business investment and a lower value of the dollar, which will make American products more competitive in the international marketplace."

Pursuant to the Conference Report on S. Con. Res. 32, the first budget resolution adopted by Congress before it adjourned for the August recess, the Finance Committee will consider various ways in which to meet its reconciliation instructions. Under the budget agreement, the Finance Committee is required to reduce spending for programs within its jurisdiction by more than $22 billion over the next three fiscal years (1986-88). In addition, Finance must raise revenues by $8.4 billion over that same period.

In addition to receiving the views of several Administration witnesses, the Committee will receive testimony from public witnesses on various proposed changes to Finance Committee programs.

All of the hearings scheduled by the Committee will begin at 9:30 a.m. in room SD-215 of the Dirksen Senate Office Building.

SUMMARY DESCRIPTION OF REVENUE PROPOSALS RELATING TO BUDGET DEFICIT REDUCTION

SCHEDULED FOR HEARINGS

BEFORE THE

COMMITTEE ON FINANCE

ON SEPTEMBER 11-13, 1985

PREPARED BY THE STAFF

OF THE

JOINT COMMITTEE ON TAXATION

INTRODUCTION

The Senate Committee on Finance has scheduled public hearings on September 11-13, 1985, on certain revenue-related proposals in the President's fiscal year 1986 budget proposal, and certain other revenue proposals discussed in connection with the Budget Resolution deficit reduction requirement, including the revenue provisions in H.R. 3128 as reported by the House Committee on Ways and Means (H. Rep. No. 99-241, Part 1; July 31, 1985).

This pamphlet,[1] prepared in connection with the hearings by the staffs of the Joint Committee on Taxation and the Committee on Finance, provides a summary description (and estimated revenue effects) of seven revenue-related proposals:[2] (1) Black Lung Disability Trust Fund and coal excise tax; (2) Customs Service fees and compliance provisions; (3) coverage of railroad workers under Federal-State unemployment compensation and the railroad unemployment repayment tax; (4) Railroad Retirement benefits; (5) Internal Revenue Service fees and compliance measures; (6) social security and medicare coverage for State and local government employees; and (7) deposit of social security payroll taxes for State and local governments. Finally, the pamphlet provides estimates on the overall budget impact of the budget resolution revenue proposals.

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[1] This pamphlet may be cited as follows: Joint Committee on Taxation, *Summary Description of Revenue Proposals Relating to Budget Deficit Reduction* (JCS-37-85), September 10, 1985.

[2] Discussion of the proposed increase in Pension Benefit Guaranty Corporation (PBGC) premiums is included in the Finance Committee staff pamphlet, *Background Data on Fiscal Year 1986 Spending Reduction Proposals Under Jurisdiction of the Committee on Finance* (S. Prt. 99-79), September 1985.

SUMMARY DESCRIPTION OF REVENUE PROPOSALS

1. Black Lung Disability Trust Fund and Coal Excise Tax

Present Law

A manufacturers excise tax is imposed on domestically mined coal (other than lignite) that is sold or used by the producer of the coal. The rate of tax is $1 per ton for coal from underground mines and 50 cents per ton for coal from surface mines, but the tax cannot exceed four percent of the price for which the coal is sold.[3] The Black Lung Benefits Revenue Act of 1981 (P.L. 97-119) doubled the original rate of the tax, effective January 1, 1982, and made certain amendments relating to the Trust Fund.

Amounts equal to the revenues collected from the coal excise tax are automatically appropriated to the Black Lung Disability Trust Fund.[4] The Trust Fund pays certain black lung disability benefits to coal miners (or their survivors) who have been totally disabled by black lung disease in cases where no coal mine operator is found responsible for the individual miner's disease.

Administration Proposal

The Administration's fiscal year 1986 budget proposal indicated that the coal excise tax would be increased sufficiently to freeze the cumulative deficit in the Black Lung Disability Trust Fund over the next five years.

The Department of Labor testified in support of the increased coal excise tax rates approved in the Ways and Means Committee bill (H.R. 3128).[5] as described below.

Status of Black Lung Disability Trust Fund

At the end of fiscal year 1984, the Trust Fund had a cumulative deficit of approximately $2.5 billion (see table below); this amount represents advances from the general revenues which are repayable with interest. The Department of Labor estimates that, unless the present rates of the coal excise tax are increased, this deficit could reach $30 billion by 2010.

The following table shows the receipts and expenses of the Black Lung Disability Trust Fund for fiscal years 1978-1984.

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[3] On the earlier of January 1, 1996, or any January 1 after 1981 on which there is no balance of repayable advances to the Trust Fund and no unpaid interest on such advances, the tax rates are scheduled to return to the pre-1982 rates, which were one-half the current rates (i.e., 50 cents/ton for underground mines, and 25 cents/ton for surface mines, limited to two percent of the price for which the coal was sold).

[4] Revenues from so-called "penalty" excise taxes on certain activities (e.g., self-dealing, excess contributions) of black lung benefit trusts also are automatically appropriated to the Trust Fund.

[5] Testimony of Susan Meisinger, Deputy Undersecretary for Employment Standards, Department of Labor, before the House Committee on Ways and Means, June 19, 1985.

Black Lung Disability Trust Fund Receipts and Expenses, Fiscal Years 1978–1984

[In millions of dollars]

Fiscal year	Receipts			Expenses		
	Coal excise tax	Interest	Advances from general fund (deficit)	Benefit payments	Administrative expenses	Interest on advances
Actual:						
1978	92.1	1.2	18.9	76.8	35.3	
1979	221.6	.1	400.8	582.0	32.1	7.7
1980	272.3		535.8	721.7	34.2	52.5
1981	236.6		554.8	644.3	35.6	109.5
1982	490.7	.3	283.0	578.2	35.8	160.6
1983	493.7	.3	357.8	623.1	34.8	193.3
1984	518.5	.4	346.1	594.2	36.6	234.5
Total	2,325.5	2.3	2,497.2	3,820.5	244.6	748.1

Source: Fourth Annual Report on the Financial Condition and Results of Operations of the Black Lung Disability Trust Fund (Department of Treasury, Sept. 30, 1981), and Budget of the U.S. Government Appendixes for fiscal years 1984, 1985, and 1986.

Ways and Means Committee Bill (H.R. 3128)

H.R. 3128, as reported by the Committee on Ways and Means, would increase the per-ton coal excise tax rate (and the sales price ceiling), beginning January 1, 1986, as shown in the following table:

Calendar year(s)	Tax on underground coal	Tax on surface coal	Ceiling (percent of sales price)
1986–1990	$1.50	$0.75	6.0
1991–1995	$1.60	$0.80	6.4
1996–	$1.50	$0.75	6.0

In lieu of the rates shown in the above table for 1996 and later years, the 1985 rates ($1 or 50 cents per ton, four percent ceiling) would be reinstated for any calendar year after 1995 if throughout the two most recent fiscal years ending before the beginning of such calendar year there was no balance of repayable advances made to the Trust Fund, and no unpaid interest on such advances.

Revenue effect.—This provision in H.R. 3128 is estimated to increase net fiscal year budget receipts by $213 million in 1986, $229 million in 1987, $236 million in 1988, $246 million in 1989, and $256 million in 1990.

2. Customs Service Fees and Compliance Measures

a. Customs Service fees

Present Law

The U.S. Customs Service does not currently have the general legal authority to collect fees for the processing of persons, aircraft, vehicles, vessels, and merchandise arriving in or departing from the United States. The Customs Service does have limited authority to charge fees under certain limited circumstances, e.g., when providing services (such as pre-clearance of passengers and private aircraft) which are of special benefit to a particular person. The Customs Service also has the authority to assess fees on operators of bonded warehouses and foreign trade zones and on the entry of vessels into ports and are authorized to receive reimbursement from carriers for overtime for services provided during nonbusiness hours and reimbursement from local authorities for services provided to certain small airports.

Administration Proposal

Both the House and Senate Budget Resolutions contained a proposal to authorize the Customs Service to assess a fee for processing common carriers, passengers, and commercial import arrivals in the United States. The Administration has testified[6] in support of allowing the Customs Service to assess fees on virtually all Customs import and export transactions. The fee schedule would be based on an analysis of the costs (both direct and indirect) of the services provided. It is estimated in the Budget Resolutions that such fees would increase fiscal year budget receipts by nearly $500 million per year.

Ways and Means Committee Bill (H.R. 3128)

H.R. 3128, as reported by the Committee on Ways and Means, would set customs fees on the arrival of commercial vessels over 100 tons ($425), trucks ($5), trains ($5 per car), private yachts, boats and general aviation aircraft ($25 per year), and on passengers arriving on commercial aircraft trains and vessels ($1 for contiguous countries, U.S. territories and adjacent lands, and $5 for all other countries).

Receipts from such fees would be deposited in the Treasury as miscellaneous receipts and placed in an identifiable proprietary account. These new fees would be effective 180 days after the date of enactment, and remain in effect for a three-year period.

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[6] See testimony of U.S. Customs Service (Robert P. Schaeffer, Assistant Commissioner, Commercial Operations, and Michael H. Lane, Deputy Assistant Commissioner, Office of Inspection and Control), before the House Committee on Ways and Means, June 19, 1985.

The bill would further provide that, with regard to the processing of passengers on scheduled airline flights arriving in the United States, no additional charges (such as for overtime for customs officers) may be assessed against the airlines or passengers other than the fees established by the bill. All other overtime charges would continue to be collected as under present law.

Revenue effect.—This provision in H.R. 3128 is estimated to increase fiscal year budget receipts by $75 million in 1987, $230 million in 1987, $240 million in 1988, and by $170 million in 1989.

b. Customs Service compliance measures

Present Law

The Customs Procedural Reform and Simplification Act of 1978 (P.L. 95-410) provides for the annual authorization of appropriations for the U.S. Customs Service. In the 10-year period, 1976-1985, Customs' staff increased by 38 positions, from 13,380 to 13,418.

Administration Proposal

The Customs Service submitted a budget request for fiscal year 1986 of $699.5 million, which included $639.1 million for salaries and expenses and $60.4 million for operations and maintenance of the Customs air program. This request proposed cuts of about 887 Customs positions.[7]

Ways and Means Committee Bill (H.R. 3128)

H.R. 3128, as reported by the Committee on Ways and Means, would authorize appropriations of $769.1 million for the Customs Service for fiscal year 1986, or about $69.5 million higher than proposed by the Administration. This would restore the proposed cut in Customs positions and add 800 new front-line Customs officers, with the new personnel (as indicated by the Committee Report) to be allocated to those port facilities having the greatest import volume and complexities.

In addition, H.R. 3128 would direct that any savings in salaries and expenses resulting from the consolidation of administrative functions within the Customs Service is to be used to strengthen the commercial operations of the Service by further increasing the number of inspector, import specialist, and other line operational positions. Further, the bill would preclude the Customs Service from closing any port of entry during fiscal year 1986 which during fiscal year 1985 processed not less than $1.5 million in Customs revenues. The bill also would make a number of other administrative changes.

Revenue effect.—This provision in H.R. 3128 is estimated (in the Ways and Means Committee Report) to increase fiscal year budget receipts (assuming continuation of the added staff throughout the 3-year period) by $150 million in 1986, $450 million in 1987, and $615 million in 1988, for a total of $1,215 million for 1986–1988.

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[7] See also Customs Service testimony referenced in Note 6, *supra*.

3. Coverage of Railroad Workers Under the Federal-State Unemployment Compensation System; Railroad Unemployment Repayment Tax

Present Law

Present law provides a railroad unemployment compensation program that is separate from and different than the regular Federal-State unemployment compensation system. Most workers in other industries are covered under the Federal-State unemployment compensation system.

The Railroad Unemployment Insurance (RRUI) program is administered by the Railroad Retirement Board (RRB), which collects the unemployment taxes directly from rail employers. Legislation enacted in 1959 provided the Railroad Unemployment Insurance Account with the authority to borrow from the Railroad Retirement Account when funds in the RRUI Account are not sufficient to meet benefit payments. This borrowing authority expires September 30, 1985. On that date, the outstanding debt to the retirement account is estimated to be $783 million, of which $526 million is principal and $257 million is accumulated interest.

There is no automatic mechanism in the law to repay loans from the retirement account as they occur. Loans are repaid out of basic contributions to the unemployment account when the Railroad Retirement Board determines that there are sufficient funds in the unemployment account to make a repayment.

The Railroad Retirement Solvency Act of 1983 established a repayment tax scheduled to begin on July 1, 1986 and to expire on September 30, 1990. The tax rate will begin at 2.0 percent and increase by 0.3 percentage points a year up to a maximum of 3.2 percent in 1990. The tax is scheduled to expire on January 1, 1991. The tax is paid on the first $7,000 in wages paid annually to a rail employee.

Administration Proposal

The Administration proposes to cover railroad workers under the Federal-State unemployment compensation system. New railroad claimants would claim regular State benefits as of October 1, 1985.

Railroad employers would reimburse the States for the cost of these benefits until the States had sufficient experience with paying benefits to railroad workers. Not later than January 1989, the States would apply their normal experience-based tax rates to railroad employers. No change would be made in the current debt repayment tax on railroad employers. Also, rail labor and management would be authorized to bargain collectively for sickness benefits which, under present law, are provided through the unemployment program.

The Administration proposal would be effective on October 1, 1985.

Estimated Outlay and Revenue Effect of Administration Proposal

[In millions of dollars]

	Fiscal year			
	1986	1987	1988	1986–88
Unemployment tax	146	157	161	464
Modify benefits	−3	3	10	10
Total	143	160	171	474

Ways and Means Committee Bill (H.R. 3128)

Under H.R. 3128 as reported by the House Committee on Ways and Means, the railroad unemployment insurance system would be modified in the following respects, effective on October 1, 1985.

(1) The loan repayment tax, scheduled to begin on July 1, 1986 at a 2-percent rate with increases of 0.3 percent a year, is amended as follows:

	Calendar year				
	1986	1987	1988	1989	1990
	Tax Rate (%)				
Present law	2.0	2.3	2.6	2.9	3.2
Ways and Means Committee bill	4.3	4.7	6.0	2.9	3.2

(2) The RRUI Account's authority to borrow from the Railroad Retirement Account is extended, effective October 1, 1985.

(3) An automatic surcharge of 3.5 percent on an annual wage base of $7,000 would be levied if the RRUI Account has to borrow from the retirement account. The surcharge would be used to repay such additional borrowing.

Estimated Revenue Effect of H.R. 3128

[In millions of dollars]

	Fiscal year			
	1986	1987	1988	1986–88
Ways and Means Committee bill		101	98	199

4. Tax Treatment of Railroad Retirement Benefits

Present Law

Under present law, a portion of Railroad Retirement system benefits computed by using the social security benefit formula (tier 1) are subject to Federal income tax for individuals whose incomes exceed certain levels (generally, $25,000 for unmarried individuals and $32,000 for married individuals filing a joint return). (These benefits may be available at an earlier age under the Railroad Retirement system then under the social security system). Other benefits under the Railroad Retirement system are subject to Federal income tax for all recipients to the extent the payments exceed the amount of the individual's previously taxed contributions to the plan.

Administration Proposal

Under the Administration proposal, a portion of tier 1 Railroad Retirement benefits would continue to be taxed in the same manner as social security benefits. This portion equals the amount of the annuity under the Railroad Retirement Act of 1974 that equals the social security benefits to which the individual would have been entitled if all of the individual's employment on which the annuity is based had been employment for social security benefit purposes. In addition, a minimum monthly annuity benefit (described in sec. 3(f)(3) of the Railroad Retirement Act of 1974) would be taxed in the same manner as social security benefits. Other tier 1 Railroad Retirement benefits would be taxed under the rules that apply to all other payments under the Railroad Retirement system.

Thus, Railroad Retirement disability benefits generally would be fully taxable if they are payable to individuals who would not be entitled to social security disability benefits or are in excess of the social security disability benefits to which an individual would be entitled. Similarly, Railroad Retirement benefits that are payable at an age earlier than social security benefits or in an amount greater than social security benefits would be fully taxable.

This provision would be effective for monthly benefits for which the generally applicable payment date is after December 31, 1985.

Revenue effect.—This provision in H.R. 3128 is estimated to increase fiscal year budget receipts by $34 million in 1986, $62 million in 1987, $65 million in 1988, $65 million in 1989, and $63 million in 1990.

Ways and Means Committee Bill (H.R. 3128)

H.R. 3128, as reported by the Committee on Ways and Means, includes the Administration proposal on the tax treatment of railroad retirement benefits.

5. Internal Revenue Service Fees and Compliance Measures

a. IRS user fees

Present Law

The Internal Revenue Service (IRS) does not currently charge businesses, individuals, or other taxpayers for issuing determination letters or rulings submitted by such taxpayers.

In 1983, the IRS issued 135,234 advance determination letters on the qualification of corporate and self-employed pension plans. The IRS acted on 53,947 determination letters and ruling requests from tax-exempt organizations during that year. The IRS also issued 34,399 private letter rulings in response to taxpayer requests during that year.

Administration Proposal

The Administration proposes to impose a user fee of $100 for each determination letter and private letter ruling issued by the Internal Revenue Service.[8] These fees are proposed to become effective on October 1, 1985.

b. IRS tax compliance initiative

Present Law

In fiscal year 1985, there are approximately 29,000 examination employees at the Internal Revenue Service. These employees are responsible for auditing tax returns.

Administration Proposal

For fiscal year 1986, the Administration initially proposed 86,489 staff positions for the IRS and a total budget of $3.5 billion. This was a decrease of 1,254 staff positions and $30.4 million from the fiscal year 1985 appropriation (including requested amounts).

The Administration proposal would increase the number of examination employees by 2,500 a year for fiscal years 1987, 1988 and 1989, resulting in an aggregate increase in examination employees of 7,500 by the end of fiscal year 1989. Advance hiring would begin in fiscal year 1986.

Ways and Means Committee Bill (H.R. 3128)

The Ways and Means Committee bill (H.R. 3128) endorses the recommendation of the House Appropriations Committee (in H.R. 3036). H.R. 3036 restores the Administration's proposed reductions in the fiscal year 1986 IRS budget and provides for an increase of $178 million over the Administration's proposed budget for fiscal year 1986.

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[8] See testimony of James Owens, Deputy Commissioner of the Internal Revenue Service, before the House Committee on Ways and Means, June 19, 1985.

Revenue effect.—This provision in H.R. 3128 is estimated to increase fiscal year budget receipts by $228 million in 1986, $465 million in 1987, $580 million in 1988, $640 million in 1989, and $708 million in 1990.

6. Mandatory Coverage of Employees of State and Local Governments under Social Security and Medicare

Present Law and Background

Under the Old Age, Survivors, and Disability Insurance program (commonly referred to as social security) and the Hospital Insurance program (commonly referred to as Medicare), coverage for State and local government employees is optional. An election for coverage under the Social Security Act includes both programs. Approximately 10.1 million (or some 68 percent) of the 14.8 million persons whose major employment in 1981 was with State and local governments were covered by social security. Under the law, a State controls the option for itself and its subdivisions; however, most often State governments allow their political subdivisions to make their own choices.

When elected, coverage is provided on a group basis through agreements between the State and the Secretary of Health and Human Services. Coverage can be provided even when the State or local government already has a retirement system in place. When there is no retirement system in place, the State or local government entity, not the employees, has the option to choose social security. However, if there is a system already in place, then the Governor or a designee must conduct a referendum of the employees involved.

In the original Social Security Act, employment by State and local governments was omitted altogether from social security coverage. The 1950 Social Security Amendments permitted State and local governments to elect coverage if their employees were not already in positions covered under a pension plan (beginning in 1951). This decision was to reside solely with the State or local government, not with the employees themselves.

The Social Security amendments of 1954 extended coverage to State and local employees who were in positions already covered under a State or local pension plan, provided coverage was agreed to through a referendum by a majority of all employees who were members of the pension plan. The 1956 Amendments further provided that, in certain States, if State or local government employees who already were covered by a pension plan were divided about joining social security, coverage could be given only to those who wanted it, provided that all new employees of the group would be mandatorily covered. This provision originally applied to eight specified States and what was then the Territory of Hawaii, at the request of these entities. At present, however, the provision is available to 21 specified States and all interstate instrumentalities.

Most State-level employees participate in social security. The major exceptions are State employees of Alaska, Colorado, Louisiana, Maine, Massachusetts, Nevada, and Ohio, where none or only a small percentage of employees is covered. Alaska is the only state that opted out of the system (in 1980).

The majority of State and local government employees who are not covered by social security work at the local level, including employees of such large cities as Atlanta, Boston, and Cleveland. Policemen, firemen, and teachers are less likely to be covered under social security than other State and local government employees, but many of them have coverage under an alternative pension system.

Until April 1983, the law permitted the termination of coverage for employees covered under an agreement, if the State or local entity (through the State) had given two-years' advance notice. This provision, however, was repealed in the Social Security Amendments of 1983.

Budget Conference Assumption

Under the budget conference assumption (S. Con. Res. 32), Social Security coverage under Old Age, Survivors, and Disability Insurance (OASDI) would be extended on a mandatory basis to new employees of State and local governments. This would be done in conjunction with a measure mandatorily extending Health Insurance (HI) (Medicare) coverage to current and new employees of State and local governments. Mandatory coverage under OASDI would apply to all new hires of State or local governments, effective beginning on January 1, 1986. Mandatory coverage under Medicare would apply to current employees as well as new employees effective on January 1, 1986.

The budget conference agreement assumes the following revenues would result from enactment of this measure:

Revenues Assumed Under S. Con. Res. 32

[In millions of dollars]

	Fiscal years			
	1986	1987	1988	1986–88
OASDI revenues	192	692	1,124	2,008
HI (Medicare) revenues	1,524	2,332	2,390	6,376
Total	1,746	3,024	3,614	8,384

Ways and Means Committee Bill (H.R. 3128)

H.R. 3128, as reported by the House Committee on Ways and Means, would extend Medicare coverage on a mandatory basis for newly hired employees of State and local governments. Employers and employees would become liable for the hospital insurance portion of the social security tax, and employees would earn credit toward Medicare eligibility based on covered earnings. Mandatory coverage would be extended only for Medicare and only for employment not otherwise covered under voluntary State coverage agreements.

H.R. 3128 would apply to services furnished after December 31, 1985, by employees hired after that date.

Estimated Revenue Effect of H.R. 3128

[In millions of dollars]

	Fiscal Year			
	1986	1987	1988	1986-88
HI (Medicare) revenues	53	191	293	537

7. Deposit of Social Security Payroll Taxes for Covered Employees of State and Local Governments

Present Law

States currently are required to make deposits twice a month of social security contributions on their own behalf and for sub-State entities. The States are liable for all such payments under current agreement with the Secretary of Health and Human Services.

Private employers are required to make tax payments under a schedule that generally relates the frequency of deposits to the amount of taxes withheld. Large employers may make deposits as frequently as twice a week, while small employers may make them as infrequently as once every three months.

Late deposits by State governments are subject to an interest charge of 6 percent. Private sector employers pay an interest rate which is based on the prime interest rate charged by major commercial banks.

Administration Proposal

The Administration budget proposal would remove the States from the intermediary role of collecting contributions from sub-State entities and put all State and local government employers under a direct depositing requirement with a schedule that conforms with the frequency required of private employers. States would be relieved of liability for the contributions owed by sub-State governments. In addition, the proposal would subject State and local governments to the same interest charge for late deposits as is imposed on private employers.

The proposal would be phased in over a two-year period, beginning January 1, 1986.

Estimated Revenue Effect of Administration Proposal

[In millions of dollars]

	Fiscal year			
	1986	1987	1988	1986–88
Deposit requirement for State-local government social security payroll taxes	400	100	300	800

BUDGET RESOLUTION IMPACT OF REVENUE PROPOSALS

Administration Budget Proposal

The President's fiscal year 1986 budget proposal includes revenue-increase items totaling an estimated $1.40 billion in fiscal year 1986, $1.7 billion in fiscal year 1987, and $3.1 billion in fiscal year 1988. These amounts include proposals relating to extension and expansion of Superfund tax revenues, increases in revenues for the Black Lung Disability Trust Fund and Inland Waterway Trust Fund, and certain changes in tax deposit and enforcement provisions.

Budget Resolution Revenue Proposals

House Budget Resolution

H. Con. Res. 152, the House-passed budget resolution, recommended fiscal year budget receipts of $794.1 billion in 1986, $866.0 billion in 1987, and $955.6 billion in 1988. These levels included recommendations for increased revenues to finance a reauthorized and expanded Superfund, increased compliance and enforcement of trade and tax laws, and other minor changes. The revenue increases, which are included in the totals mentioned above, amounted to $1.45 billion in 1986, $1.7 billion in 1987, and $3.1 billion in 1988, or $6.25 billion for 1986–1988.

Senate Budget Resolution

S. Con. Res. 32, the Senate-passed budget resolution, recommended fiscal year budget revenue levels of $793.6 billion in 1986, $866.3 billion in 1987, and $955.9 billion in 1988. These recommendations included revenue increases of $0.9 billion in 1986, $2.0 billion in 1987, and $3.4 billion in 1988, or $6.3 billion for 1986-1988.

Conference Budget Resolution

S. Con. Res. 32, as agreed to by the conference and as passed by the House and Senate, sets fiscal year budget revenue levels of $795.7 billion in 1986, $869.4 billion in 1987, and $960.1 billion in 1988. These levels include revenue increases of $3.0 billion in 1986, $5.1 billion in 1987, and $7.6 billion in 1988, or $15.7 billion for 1986–1988.

Budget Revenue Reconciliation Provisions

The conference agreement on S. Con. Res. 32 includes revenue reconciliation instructions for the Committee on Finance to increase fiscal year revenues by $1.8 billion in 1986, $3.0 billion in 1987, and $3.6 billion in 1988, or $8.4 billion for 1986-1988.

STATEMENT OF SENATOR DOLE

FINANCE COMMITTEE BUDGET HEARINGS

Mr. Chairman, these hearings are an important step toward completing action on the budget for fiscal year 1986. This has been a long hard road, and our progress on the budget is a lot less than many of us had hoped for. But that doesn't mean we shouldn't do everything we can to achieve the savings in the budget resolution. That's what these hearings are all about.

We should not pretend, either, that this committee has been given an easy task under our budget resolution. There are some difficult choices before us, Mr. Chairman and we appreciate your leadership in moving expeditiously—to complete action on the budget.

FINANCE COMMITTEE TARGETS

A brief examination of our budget targets in this committee shows how important our budget responsibilities are. Over a three-year period, the budget assumes we will reduce Medicaid spending by $450 million—save $10.855 billion in Medicare—save $8.482 billion by letting general revenue sharing expire—and reduce the deficit another $8.4 billion by raising PBGC insurance premiums, imposing premiums, imposing customs service user fees, and expanding Social Security and Medicare coverage of State and local government employees. That is a total of over $30 billion in savings over 3 years, and it is not an easy order. We can do the job, though, if we keep in mind the stakes in this budget debate.

The fact is that everything we have achieved for the economy in the last several years is put at risk unless we deal with the deficit. And part of the problem is that the public can't get very excited about the deficit dilemma. It seems we need to have a crisis on our hands, or some kind of visible faltering in the economy, to convince people of the urgency of reducing the budget deficit.

THE REAL POINT

Sustained deficits in the $200 billion range are a real threat to continued recovery. They will mean either higher inflation or slow growth and rising unemployment. Without assurance that inflation will remain under control and credit available at acceptable rates of interest, business will not expand through new investment, and jobs will not be available for our sons and daughters when they are ready to enter the workforce.

All our economic problems: lower growth, huge trade imbalance, and restrictive interest rates—are linked to the deficit problem. That is why we urgently need to reach agreement on the specific steps needed to achieve the savings mandated by the budget resolution. That is the least we can do: and we should be doing a lot more.

OPENING STATEMENT OF SENATOR DAVE DURENBERGER

SENATE COMMITTEE ON FINANCE, HEARING ON BUDGET RECONCILIATION, SEPTEMBER 11, 1985

As members of the Finance Committee we are faced with a very onerous task—to raise $8.4 billion in new revenues over the next three years. While this amount pales in comparison to the revenues raised by our government each year, we are no longer free to tinker with the tax code without coming to grips with what has become the benchmark of all tax proposals—revenue neutrality.

Under these circumstances, coming up with $8.4 billion is like searching for a needle in a haystack. Now, I know that many of you testifying today on whether state and local employees should be brought into the Social Security system feel that this is yet another case where state and local governments have been singled out to bear the brunt of deficit reduction. But you also know that as Chairman of the Intergovernmental Relations Subcommittee, that I have always cast a critical eye upon those proposals, such as eliminating deductibility and eliminating General Revenue Sharing, which may be regarded as easy solutions to difficult problems but are really ill-judged and unfair.

But when it comes to the issue at hand, I had to ask myself whether it is fair that state and local employees are not required to participate in the Social Security system when just about everyone else who works in this country is. And I really questioned the fairness of the exclusion upon learning that the majority of state and local employees will receive Social Security benefits because of work performed in the private sector either prior or subsequent to public employment. And it's my understanding that by and large, these folks will have contributed significantly less than others who become entitled to benefits after paying into Social Security during all of their working years.

This inequity puts a financial drain on the system. This is especially true in the case of the Medicare hospital insurance portion of the Social Security system because the benefits are the same for everyone who is entitled. So it doesn't seem entirely fair to me that employees in some state and local governments are excluded from participating in Social Security.

Because the greatest inequity surrounds the issue of Medicare coverage I feel that all state and local employees should be required to participate in Medicare. And if push comes to shove, I can go along with new hires being required to participate in both Social Security and Medicare. However, I am aware that a starting date of January 1, 1986 could create some problems for state and local governments because they are already will into their budget year.

Their revenues are already fully committed to schools and teacher salaries, hospitals and health care, police and fire protection, welfare and Medicaid and all the other important services that state and local governments provide. And unlike you or I, state and local governments can not use VISA or MasterCard to cover unexpected expenditures. So, requiring mandatory coverage as of January 1, 1986 would not only rob the bank, it would also break it. Additionally, it will take time for these governments to make the necessary revisions to their benefit plans. So, I would propose that we delay the implementation of this proposal at least until July 1, 1986, which would be the start of their fiscal year.

Another central issue before this Committee concerns the elimination of General Revenue Sharing. As we all know, the President proposed, and Congress agreed, to terminate GRS at the end of FY86.

The reasons for this decision are not difficult to understand. GRS is a major budget item—costing the federal government $4.6 billion per year. Moreover, it's a program whose original justification appears to have faded since it was first established in 1972. The Federal Government now faces a deficit crisis. It no longer has surplus revenues to share.

Though understantdable, the decision to terminate GRS is a particulary difficult one for those of us who have been longterm supporters of the program. Although it is not without its flaws, GRS has been the bedrock of an historic effort to reform the federal system—a purpose which is just as important today as it was 15 years ago.

Revenue sharing is truly unique. It is the only program that goes to practically every local government in the country, including many which receive no other form of Federal assistance.

Revenue sharing is the only source of Federal aid that remains virtually unencumbered by lengthy Federal restrictions and paperwork requirements. In fact, GRS funds are often used to pay for unfunded mandates imposed by other Federal programs.

Finally, GRS monies are distributed in a relatively targeted manner. Per capita Revenue Sharing payments range from almost $30 per person in our poorest communities to less than $5 per person in the nation's wealthiest jurisdictions.

In short, if we accept the need for cuts in Federal spending—which I do—this may well be the wrong program to eliminate. In better budgetary circumstances, I would argue that this program be expanded, not eliminated. I have in the past been a strong advocate of enlarging GRS and giving it a permanent source of federal revenues.

But today we are confronting a budgetary crisis. We must examine every program with the utmost scrutiny. We must develop new solutions to our problems. The Federal Government no longer can afford to share revenues it does not have with communities like Beverly Hills, California and Greenwich, Connecticut. As the Federal Government reduces its overall role, however, it must assure that communities that face reduced Federal aid and growing servicing responsibilities have the minimum fiscal capacity to meet their growing needs. We must assure that General Revenue Sharing fulfills its fundamental role as a mechanism that mitigates fiscal disparities, and does it in the most efficient manner possible. We must, in short, refashion GRS as a fiscal safety net for needy communities.

Later this fall I plan to introduce legislation which will reauthorize and revise GRS and give it a stronger, more contemporary rationale. The major features of this substantially revised program will be a 50 percent reduction in the program's authorization. This will make a significant contribution to deficit reduction. Second, in order to make these reduced funds stretch farther, I will propose altering the Revenue Sharing formula at both the interestate and substate levels. The interstate formula will be amended to account more accurately for differences in the revenue raising abilities of different states. Better targeting will be achieved within states by substantially increasing the proportion of aid going to communities with few resources, while reducing and even eliminatng aid to jurisidictions that stand well above the state average in fiscal capacity.

These are sweeping and dramatic changes. By providing assistance in a targeted manner to communities that need it most, they will fill a major gap in the intergovernmental fiscal system.

Can we afford it? In a time when we are cutting and eliminating other intergovernmental programs and tax expenditure, I believe we have no choice. But sustaining revenue sharing, no matter how restructured, will be expensive. Even with a budget cut of $6.9 billion over three years, a safety net program for poor communities will cost the treasury $2.3 billion per year.

Therefore, I am prepared to support folding in funds from other federal programs that this nation no longer can afford. Like the existing GRS program, many of these are useful activities that would be worthy of support in less demanding times. Some, like EDA and the Appalachian Regional Commission, address goals similar to a retargeted GRS, but they do so less efficiently. Additional funds can be drawn from cuts in a variety of education and training programs which the Senate agreed to make this year but were not included in the Budget conference totals. Additional revenues can be obtained by allocating 4 of the existing cigarette tax, currently scheduled for elimination. Taking all of these actions would generate $2.5 billion in FY 1987, which is enough to fund a revenue sharing program at more than 50 percent of current funding levels.

As all of us are well aware, we are in a difficult period. The decisions we face are not easy ones. This is true for state and local governments as well. Some of them may think that what I am proposing amounts to robbing Peter to pay Paul.

But that is not the case. The safety net program I am proposing is the governmental counterpart of the social safety net. We all accept that the Federal Government has a responsibility to provide a level of income security to individuals who are unable to support themselves. But it is also true that such people are not spread randomly across the country. They tend to be clustered in our poorest states and communities. Just as the nation has a responsibility to establish a minimum floor or support below which our poorest citizens will not be allowed to fall, I believe it has a similar responsibility to assist those governments which are hardpressed to provide a minimal level of basic public services.

Even in these difficult fiscal times, I believe this must be a priority of Federal Government. As long as there are ongoing activities of this government which fail to meet as stringent a test of legitimate national purposes, I would maintain that it is the duty of this Committee to find the resources necessary to fund such a program.

STATEMENT OF BY SENATOR PETE WILSON

Mr. Chairman, I appreciate the opportunity to submit testimony for the record as your committee continues its efforts to meet the deficit reduction goals that are so important to a strong and prosperous economy. Mr. Chairman, I share your concerns regarding the reduction of the federal deficit as the budget crisis continues to be my highest legislative objective for the 99th Congress.

As the distinguished members of this committee continue to address the deficit reduction issue, I would like to highlight the potential grave implications that the cumulative impact of these deficit reduction efforts may have on my State and its political subdivisions. While Congress must make some difficult deficit reduction choices, Congress must make sure that the net impact of these choices does not prevent State and local governments from meeting their most important responsibilities. I raise these concerns because the cumulative impact of the proposed budget resolution, taken with other federal mandates, may be more than State and local governments can endure.

To that end Mr. Chairman, I have real concerns about present proposals to force State and local governments to participate in Social Security and Medicare. While I agree that corrective actions may be necessary to strengthen the Medicare system, I am concerned that mandatory coverage does not address the root of the problem.

A summary of the budget reductions and mandates that have recently impacted State and local governments highlights the potential threat to ability to these entities to meet their constitutional mandates.

First and foremost is the loss of revenue sharing. Cities are also facing a 15 percent reduction in the community development block grant program, a 20 percent decrease in urban development action grants, and significant reductions in mass transit and other important city programs.

At the same time that local governments are adjusting their budgets and programs to meet these budget changes, they have also been working to meet the mandates of the Supreme Court's decision in *Garcia* v. *San Antonio Transit Authority.* The *Garcia* decision requires States and their political subdivisions to implement the Fair Labor Standards Act (FLSA) which prevents the use of comp time in lieu of time and one half. FLSA is expected to cost California between $350-$500 million without any increase in the level of services they presently offer.

Similarly, the present tax reform proposals which include the loss of State and local tax deductibility, and new restrictions on tax-exempt bond financing pose an equally difficult revenue problem for State and local governments.

Aside from the impact of the above changes on the fiscal viability of State and local governments is the issue of mandatory enrollment for State and local employees in Social Security and Medicare. In California, 60 percent of the State and local government employees and teachers have bargained to participate in public employee retirement systems that they believe will best meet their health and retirement needs. Congress is now considering mandating local and State participation in Social Security and Medicare.

While 70 percent of the Nation's State and local employees are presently covered by Social Security and Medicare, this new mandatory tax will have a severe impact on localities and States which have opted for independent retirement programs. In effect, those State and local governments that have seized the initiative to provide health and retirement needs for their employees will be penalized for their self-help efforts with the high cost of a Social Security-Medicare mandate.

The cumulative impact of all of these reductions and mandates is potentially devastating for my State and its local governments. It costs the county of Low Angeles $50 million for the FLSA, $80 million in revenue sharing losses, $30 million because of Social Security and Medicare. The city of Los Angeles faces reduction of $54 million for revenue sharing, $10 million for CDBG, $32.4 million for Medicare and Social Security and additional costs of $100 million for the FLSA implementation. The cumulative impact of these changes on the State of California is staggering. It is estimated that of the $8.4 billion to be generated by mandatory Social Security and Medicare that 26 percent or $2.184 billion will come from California. This is in addition to reductions of $507 million, $3.8 billion, $72 million and $500 million for revenue sharing, State and local deductibility, CDBG and FLSA respectively.

Mr. Chairman, I want you and my colleagues on the committee to know that I can appreciate the arguments in favor of mandatory coverage. I am aware that eventually many of the individuals that are not presently covered will eventually quality for Medicare benefits. It has been suggested that this number may reach as high as 95 percent of presently non-participating State and local employees. This is certainly a compelling reason to require coverage, particularly for Medicare where minimum qualification results in entitlement for the full range of benefits.

Additionally, it is my understanding that the Congressional Budget Office projects that hospital costs attributable to Medicare beneficiaries are projected to increase over the 1985-1990 period at an average annual rate of 10.1 percent while income is projected to grow at an annual rate of 7.6 percent. Further projections indicate that the hospital trust fund could be depleted by the middle of the next decade.

Given these facts and the continuing need for deficit reduction, I am keenly aware of the need for Congress to address these issues. However, I question whether Congress has evaluated the full ramifications of the mandatory coverate proposal. It seems to this Senator that the problems that are in the offing for the Medicare Program should not be addressed in a piecemeal fashion but throgh a comprehensive analysis and strategy.

As a firm believer in States rights, I would argue that the Federal Government should not have the authority to mandate this new tax on State and local governments and their employees. However, the *Garci* decision appears to have opened a flood gate for Federal mandates in areas that have typically been reserved for States.

I am very concerened about the suggestion that the mandate for Social Security and Medicare would be effective January 1, 1986. As the committee is no doubt aware, this significant change would be enacted in the middle of the current fiscal year for most cities, allowing no time for State and local governments to alter budget allocations or generate additional revenues to meet this new "employer" tax.

It is my understanding that the Commission on Social Security reform did not recommend mandating State and local participation despite the Commission's desire for universal participation. Given this fact, and the cost implications for State and local governments, I believe Congress must take the time to study this matter in a more thorough manner.

Additionally, the universal Social Security coverage study group published a report in 1980 which indicated that mandatory Social Security coverage would result in the transfer of significantly higher retirement costs to State and Local government. The group projected that the cost of coordinated plans—present retirement systems combined with social security—would increase benefit taxes by 5 to 8 percent of the payroll.

Finally, I would like to direct the committee's attention to remarks made by President Reagan in a press conference last month. When discussing Social Security, the President stated that "Social Security as part of the deficit is nothing but a bookkeeping gimmick." Reagan sited that Social Security presently runs a surplus and that Social Security revenues go into a trust fund which cannot be used for anything else. Therefore, the President concludes that "not one penny of it can be used to reduce the deficit in the overall management of government. To continue to say that this could somehow reduce the deficit . . . is a snare and a delusion."

Mr. Chairman, it has been my intent to site many of the problems that I see with the proposals to require mandatory Social Security coverage for state and local government employees. While, I can agree that corrective actions must be taken to strengthen the medicare system, I have reservations that mandatory coverage is but a band-aid solution to a greater problem.

Additionally, Mr. Chairman, I want to assure you and the distinguished members of this committee of my continuing and overriding commitment to deficit reduction. However, in our efforts to meet this most important goal, I ask that the committee give careful consideration to the full ramifications of the cumulative impact that deficit reduction efforts will have on local governments.

The CHAIRMAN. The committee will come to order, please.

Senator Kerry is the first scheduled witness today, and he is on his way, but Senator Durenberger has to go to an Intelligence Committee hearing that he has to chair at 10 and has some opening comments he would like to make. And I would like to call upon him now.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, I thank you very much.

I do regret that we have got two matters that couldn't be delayed past 10 this morning so that I have to leave. I wanted to share with you and my colleagues and the people that are deeply concerned about the issues that we are hearing today a couple of my concerns.

First, on the issue of Social Security, Medicare and public employees. Let me say that there is an incongruity about Social Security that I can't quite understand despite all of the efforts we put in—in 1982 and 1983 on the subject. And that is that I asked one of my staff members what's the difference in the Federal deficit if we take Social Security off the Federal budget today? And he said, well, a $220 billion deficit today would be a approximately $286 billion deficit.

Now that's astounding that the Social Security——

The CHAIRMAN. Because of the surplus in the Social Security Fund?

Senator DURENBERGER. Yes. In effect, the current surplus in Social Security.

But he said—and he's only 30 years old—he said, Senator, let me remind you that by the year 2020 we are not only out of money, but we're back in the hole again in the Social Security. That's the incredible thing we are dealing with.

So with the incongruity of that, we come to an issue that I'm sure is somewhat confusing to all of us. And it looks like we are approaching it strictly in terms of the deficit and what does $8.4 billion have to do with the deficit. And I'm sure we will hear a lot about that today.

It strikes me that, regardless of my views on Social Security, everybody in the country ought to participate in the process of supporting it since most people in the country are the beneficiaries of it.

However, I wanted my colleagues to be aware of the fact that if we adopt the recommendation to bring all the remaining State and local employees into the Social Security system, first Medicare, and then OASDI, the reality of what we are doing should not be lost on us in terms of the intergovernmental relations in this country. Because, in effect, having spent 4½ years now getting the Federal Government out of participating in the funding of State and local government delivered services, we are now about to go one step farther and add another substantial tax at the local government level to pay for nonmeans tested Federal benefits.

I just think the country ought to be aware of what we are doing here in the ultimate. We are asking the people back in Minneapolis and the school district, who pay for a good part of the cost of education out of the property tax, to raise the property tax in order to flow it through either in salary or employee contribution a payroll tax so that everybody in this country, when they reach the age of 65, can have a free health insurance plan.

And we ought to just understand that that is what we are up to. That cost is measured in the billions and will end up as a local tax passed on into a national system.

I would also suggest, Mr. Chairman, those of us who are also in governmental affairs looking at the problem of changing the retirement system for civil service at the Federal level, that the notion that somehow this change could be effected on January 1, 1986 is totally lost on me. I really think it needs to be delayed.

The last thing I wanted to say, Mr. Chairman, with regard to general revenue sharing—that's not today's subject, but I can't be here on Friday—that I intend to propose, but I'm going to propose a substitute for general revenue sharing, with another name, which is mainly a needs or means tested passthrough of Federal moneys to local government at approximately half the dollars that were in the current program, with a formula that will try to target some of these moneys toward the most needy local governments in this country.

Those formulas do exist. They have been resisted by local government associations in the past. They may be ready to consider them today.

But this committee may not be ready for it in light of the deficit. I just wanted to alert the Chair that sometime this fall I hope to be able to make a proposal for the consideration of my colleagues in that regard.

The CHAIRMAN. I think the proposal has great merit. I appreciate the warning because as a chairman himself, he knows how chairmen hate to be blindsided by something coming.

Senator Long.

Senator LONG. Mr. Chairman, I will have to go to the Commerce meeting today. I want to support Secretary Dole's position on a matter there—I think I do anyway, subject to what might be said in the meeting with regard to the airports in the Washington Metropolitan area.

I don't agree in complete detail, but I think I generally agree with her position.

And while I am not here, I just want the witnesses and everybody to know that I am strongly opposed to any further scheme to tax a State government to solve the deficit problems of the Federal Government.

Some time back the Congress, over my protest, managed to slip through a proposal which in my judgment taxes the interest on State full faith and credit bonds. And I don't think the votes are there to sustain that position. I know Senator D'Amato feels the same way I do about it. We are going to continue our fight to reverse that decision.

We don't think it is going to solve our problem to engage in a beggar-thy-neighbor program to tax the State and local government. If you take revenue sharing away from them, that's bad enough, but to go solve our problems by taxing them just doesn't make any sense. It was never intended in the formation of this country.

I just don't think we ought to spend much of our life standing for honor, conscience and principle and then suddenly say, wait a minute, that's all fine except when money gets involved—then that is something else. I think we ought to be consistent in what we do.

We have always taken the view that the Federal Government is not going to tax the State governments. This proposal, as I understand it, would tax the State governments for Social Security purposes to try to help balance the Federal budget.

I just don't think we ought to do that. And I think I'll have substantial support in fighting against that. Insofar as they can find that money, they need it to take care of their retired employees by taxing their younger ones, just as we do for our elder employees by taxing the younger ones.

I just want to get my word in here to alert everybody that I'm going to oppose taxing State and local governments. It's not that hard to find revenue for the Federal Government that we have got to clobber the State governments in order to do it.

And I hope that others will tend to feel the same way about it when the time comes.

The CHAIRMAN. Any other opening statements?

[No response.]

The CHAIRMAN. If not, we will start with our first witness. Senator Kerry. There he is. Good to have you with us this morning, John.

Senator Kerry, the junior Senator from Massachusetts.

STATEMENT OF THE HONORABLE JOHN F. KERRY, U.S. SENATOR, STATE OF MASSACHUSETTS

Senator KERRY. Thank you very much, Mr. Chairman.

I appreciate the opportunity to testify before the Finance Committee. I will submit for the record, Mr. Chairman, my formal comments, and I ask your leave to be able to submit at the same time a letter from Gov. Michael Dukakis of Massachusetts regarding the impact on the Commonwealth of Massachusetts.

The **Chairman**. That will come right behind your testimony.

Senator **Kerry**. I thank you very much.

I will just summarize, if I may, Mr. Chairman.

Massachusetts and I personally are deeply concerned about the impact of the move to place all employees under Medicare effective January 1, 1986, and all new hirees under Social Security.

We are, obviously, very mindful of the difficulties that this committee is facing in an effort to find revenue, and particularly the $8.4 billion which has been specified in the concurrent resolution.

But we are also mindful that over these past 5 years Massachusetts, as well as every other State in the Union, has again and again and again been requested to make up for cuts at the Federal level of one kind or another, some direct, some indirect.

Federal revenue sharing is going to be phased out. The CDBG's are being reduced. UDAG's are being reduced. And we are still reeling from the constitutional imposition of State property tax limitations, in our State known as proposition 2½.

But having reviewed the Federal picture with respect to those restrictions, there is almost no State in the United States of America today that isn't laboring under some kind of limitation on rate of tax increase, total amount of tax increase, property tax, and other revenues.

If you add to that the imposition of a January 1, 1986, assumption of these costs, it is simply one more burden which not rhetorically but absolutely realistically is going to make it impossible for some States to meet their financial burdens.

Now that problem is compounded by the fact that this is mid-budget for many States. And because it is a mid-budget requirement, they can't even adjust under the circumstances.

And, therefore, I would like to simply call to your attention—I can't speak for all the other States, but in Massachusetts in the first year, the total amount of both of these changes will be about $80 million. And to just put that in a perspective, we have a total of just about an $8 billion budget.

We return to our cities and towns annually in local aid somewhere in the vicinity of $150 million. So this is almost one-half of the total amount that the State government has to assist local communities in the totality of their projects and programs.

In the outyears, going out to 1990, it will be a total assumption of some $646 million. Obviously, with the largest imposition being on Medicare up front and Social Security on the back end.

The second significant problem that I would call to the attention of the committee is that we are under constitutional restriction in our ability. Even if you proceeded to do this, legally, we would have no way to remove the restrictions, if we were even trying to respond appropriately to the mandate, and would face a chaotic situation with respect to what program we would have to adjust or not adjust.

And I think that that is not the intent of the Congress.

Now over the years I know the CBO was required, I believe by a change in the budget requirements, the Budget Act, to submit to the Congress the cost of those congressionally mandated programs, at least the cost to the Federal Government.

I certainly think it would be a good idea in light of this to require CBO to also submit—and I intend at a later time to try to file legislation to do so—to file the cost to the State and local governments of those particular programs.

We have done that in Massachusetts. And, in fact, gone even further where no program can be mandated without the State—mandated on local government without the State itself being required to provide the money for that.

I'm not suggesting that that would be part of the Federal Government approach, but I am saying that you can't take this kind of action without paying closer attention, I think, to what the impact is going to be on the financial status of the States involved.

The second problem, just very quickly, is one that the Federal Government and all the members of this committee are wrestling with. And that is that administratively to take existing pension programs, many of which are obviously far more generous and have been worked on and negotiated out over the years to provide benefits that go well beyond what Social Security can provide—obviously, there is going to have to be an adjustment process. And you are going to have to work out the ability to have supplementary programs of one kind or another to make up that difference.

And there isn't a State employee or a local employee who not only will not ask for it, but doesn't have a right to ask for that. De minimis.

To ask by January 1, 1986, for the States to accomplish what the Federal Government was given 2 years to accomplish, and hasn't yet accomplished, is, again, I think, to impose a burden which is unreasonable.

So I would strongly recommend that the distinguished members of the committee who are far more versed in the budget than I and aware of the options than I, struggle somehow not to impose yet again one more burden which simply cannot be met by States that are already overtaxed.

Mr. Chairman, at the risk of going beyond the purview of this particular hearing, I don't want to come here and suggest to you that you give up $8.4 billion in revenue without at the same time saying to you that I think there are other places where you might be able to find it.

And as the chairman well knows, because he joined me on the floor in a resolution which has been included in the concurrent resolution, I am still strongly of the belief that we have not yet adequately explored the opportunities of compliance, of tax compliance, in this country.

And the figures are very clear. And if I could just take 1 minute, I would like to reiterate to this committee that the IRS itself is telling us that there are $92 billion in reported but uncollected or nonreported but collectible revenues. There are $30 billion in reported but noncollected revenues of which the IRS itself says it is only seeking to recover some $8 billion.

Now there are 14 States in this country which have undertaken special programs of compliance in the last 2 or 3 years. Each of them is a success story in and of itself, which demonstrates how through creative enforcement as well as through various measures, such as requiring task compliance certificates on an application for Federal loans or grants—they have, all of them, increased their revenues as a result.

And if a mere 10 percent compliance increase were to take place over the year, based on the figures available, that would be more than the $8.4 billion that this committee is seeking.

And the figures are very clear. Ten years ago, compliance in this country, it was estimated accurately by the IRS itself—it was at 84.6 percent. It is now down to 81 percent. And each diminution of a percentage point represents the loss of $5 billion in revenue.

So, Mr. Chairman, if we were simply at the rate of compliance that we were at 10 years ago—not an increase, not something that we haven't touched before, not something that we don't know how to do—if we weren't simply where we were 10 years ago, that would be an additional $17 billion of revenue to the coffers of the Government.

So I strongly implore the committee to look hard at the prospect—this is without an amnesty—of simply increasing our compliance and renewing people's faith in the system.

The Yankalovich study recently showed that one out of four Americans believe adamantly that less than half of all citizens comply with our tax laws, and a majority of American believe that tax cheating is becoming more prevalent. Most disturbing is the finding that 41 percent of the public indicated that they are certain that tax cheaters would not be caught. And, in fact, 1 out of 5 Americans are cheating, and only one out of 43,000 Americans are ever criminally prosecuted for that fact.

I think a system that has that kind of compliance record is a system which is inviting the record of Italy and other countries where tax compliance has become a farce.

And I think there is a great opportunity here to have fairness, equity in our system; to find revenue without imposing on the States the unfairness that I think this proposal does.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

[The prepared written statement of Senator Kerry and the letter from Governor Dukakis follow:]

STATEMENT OF

SENATOR JOHN F. KERRY

MR. CHAIRMAN - I appreciate the opportunity to come before the Senate Finance Committee this morning to express concern I have about proposals to include state and local government employees under Medicare effective January 1, 1986 and all new employees under Social Security hired on or after January 1, 1986.

The Budget Resolution, S. Con. Res. 32, has instructed this Committee to raise $8.4 billion in unspecified new revenues and this state and local government proposal is before this Committee in order to meet the $8.4 billion obligation. I oppose this proposal and wish to outline my views about the fiscal impact on my state, the problem with pension integration, and the congressional review this issue has been given.

The fiscal impact this proposal would have on state and local governments would be significant and in some cases disastrous. A January 1, 1986 effective date places the enactment in the middle of the budget year for most of the government units affected, most critically, even if state and local governments were able to raise the necessary revenue to cover the employer's share of the payroll tax, most would be unable to because of legal and constitutional restrictions. In my own state of Massachusetts, for example, the 2 1/2 percent property tax limit would make it impossible to raise the revenue needed to meet these payroll taxes.

Several states would share an especially large part of the burden of this proposal. Let me cite for you the severe penalty this would place on Massachusetts. For instance, extension of Medicare coverage will cost Massachusetts state and local governments over $70 million in 1986 and nearly $400 million over the next 5 years. To extend Social Security coverage to new employees hired on or after January 1, 1986 is estimated to cost Massachusetts $3 million in the first year and the local governments an additional $4 million in 1986. The cost estimates for the outlying years are even more dramatic with a $250 million price tag for Massachusetts state and local governments in the next five years To put this in perspective, the state's total budget for fiscal year 1986 is $8.1 billion.

I am very aware of the responsibility this Committee has to meet the instructions it received from the Budget Resolution and you have many worthy proposals before you. However, this proposal uses the balloon method of deficit reduction. Wherever we squeeze out savings, the costs spring up in higher costs for state and local governments. I personally feel, and in fact intend to file legislation, that we should require the Congressional Budget Office to cite the state and local government cost estimates with their other cost estimates on congressional proposals. You may be interested to know that Massachusetts takes a different approach, and perhaps more realistic approach, to mandating costly requirements on local governments. Massachusetts state law requires that when the state imposes new requirements or new programs on local governments, the state must provide the funds necessary to carry out the mandate. I am not suggesting the passage of an identical federal law, but do believe the concept is a valid approach for us when we pass the buck to state and local governments.

Aside from the unplanned costs to state and local governments, as well as to the employees involved, mandatory Medicare and Social Security coverage would create havoc with the existing retirement systems. State and local governments proceeded under current law to develop and administer their own retirement systems and as we all know, these contractual agreements is no small undertaking.

In trying to envision the integration of this budget proposal we must keep in mind that in many respects the benefits paid under Social Security are much less generous than those provided under current state and local pension plans Administrative confusion would ensue. Many states offer early retirement, benefit levels which are higher in proportion to earnings, and more generous disability benefits. A supplemental pension plan would be required. And again, while envisioning all of these changes, we are dealing with a January 1, 1986 effective date. The Congress allowed the federal government a two year transition period to develop its supplemental pension plan when federal employees came under Social Security in 1984. Can we expect the state and local governments to provide in a few months what the federal government has been unable to do in nearly two years?

And finally, I am concerned about the speed with which this proposal has come before the Congress. Thorough hearings have not been held on the issue of mandatory Medicare and Social Security coverage for state and local government employees. The last time it was reviewed before the Congress was in 1983 when the National Commission on Social Security Reform recommended to Congress against including state and local government employees under Medicare and Social

Security. This issue will crucially touch the futures of all the state and local government employees affected and they surely deserve more than a backdoor method of change on such a vitally important issue.

I recognize that by suggesting that you set aside this proposal it is incumbent upon me to provide an alternate revenue proposal. Let me take this opportunity to highlight an option which has demonstrated broad support in the congress this year, namely, enhanced tax compliance. As you may recall, the amendment I introduced on enforcement passed the Senate 93-2. I am happy to note that a similar enhanced tax law enforcement provision is included in S. Con. Res. 32. I am proposing that we look to that source for the additional revenue discussed here today. As noted in that language, the IRS estimates of 94B in uncollected revenue annually. Without belaboring the point, I note that the track record of effectiveness in enhanced compliance in many states stands as clear evidence that sums at least equal to the 8.4B we are discussing here today can be raised for FY '86.

In closing I would like to say that state and local governments do not pay lavish salaries. To enact this sudden change in policy will certainly diminish the ability of these governments to provide responsible and attractive retirement system. In the case of many states and local governments, a strong modern retirement system is one of the key incentives which the governmental unit offers to attract quality people. It would seem especially unequitable to include current employees under either Medicare or Social Security, but should the proposal be newly hired employees only it would still penalize current pension systems which rely on the newly hired for solvency. And finally, I fail to understand the justification of a January 1, 1986 effective date for any of these proposals.

Once again, Mr. Chairman, thank you for allowing me to testify today. I would be more than happy to respond to any questions you may have.

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE DEPARTMENT
STATE HOUSE • BOSTON 02133

MICHAEL S. DUKAKIS
GOVERNOR

September 9, 1985

The Honorable John Kerry
United States Senate
362 Russell Senate Building
Washington, D.C. 20515

Dear John:

I am writing in opposition to certain assumptions contained in the Congressionally-approved budget resolution which would bring state and local employees into the medicare/social security system. These assumed savings, which were hastily included in the final budget resolution without due consideration of their implications, would have a profound impact on governments in the Commonwealth and their employees.

As you know, the FY'86 budget resolution implicitly assumes that effective January 1, 1986, all state and local employees will be included in the medicare system and that all new hires will contribute towards the social security system. In effect, this proposal would require that, beginning January 1st, state and local governments would pay the employer share of the medicare payroll tax for all current employees and the social security payroll tax for all new hires. Likewise, the affected state and local employees would contribute an equal proportion for medicare/social security coverage.

Since virtually none of Massachusetts' nearly 300,000 state and local employees are currently included in the medicare/social security system, enactment of these proposals would have a disproportionate fiscal impact on the Commonwealth. We estimate that medicare coverage alone will cost Massachusetts state and local governments over $70 million in 1986, and nearly $400 million over the next five years. Employees of state and local governments would have to pay a similar amount as their contribution to the medicare system.

In comparison, the initial impact of the social security payroll tax is relatively small ($7 million in 1986), owing to the fact that coverage would only apply to new hires. However, the cost of social security coverage escalates dramatically over the next few years as new employees enter the state and local work force. In fact, by 1990, we expect annual expenditures for social security coverage to exceed the costs of medicare coverage. Over the next five years, social security coverage will cost state and local governments in Massachusetts approximately $250 million. Please note the attached chart documenting the dramatic fiscal consequences of these proposals for Massachusetts state and local finances over the next five years.

The financial impact of these proposals is further compounded by the January 1st implementation date. Incorporated into the budget resolution at the eleventh hour of Congressional negotiations, this additional fiscal burden could not have been anticipated by state and local governments as they developed their spending blueprints for FY'86.

In addition to the obvious fiscal disruptions created by the early implementation date, a myriad of administrative difficulties can be expected as the state and local governments attempt to integrate the social security system with present pension plans. Since current state and local pension plans are more generous in certain respects than benefits provided under social security, a supplemental plan will be required if state and local governments are to provide new employees with pension coverage comparable to that received by current employees. As you know, for the last two years, the Federal government has been struggling to design such a plan for Federal civil service employees hired after January 1984. If the difficulties encountered at the Federal level are any indication, design of state and local supplemental pension plans by the first of next year will be impossible.

The inclusion of state and local employees in the medicare/social security system represents a substantial shifting of costs to state and local governments and their employees. According to budget estimates, these proposals will raise $8.4 billion in additional Federal revenues over the next three years, an added tax burden which will be shared equally by state/local governments and their employees. In light of the anticipated costs resulting from the recent Garcia v. San Antonio Supreme Court decision, the proposed FY' 87 elimination of general revenue sharing, and the additional cuts contained in the budget resolution, implementation of mandatory medicare/social security coverage will further squeeze the limited financial resources of state and local governments. In fact, for many local governments, this added burden may threaten their ability to finance basic public services as well as pension plans serving current retirees.

I am extremely supportive of your efforts to reduce the Federal budget deficit. However, enactment of these proposals will not achieve true deficit reduction in the long term. Since medicare and social security trust fund revenues are earmarked for eventual expenditures on behalf of program recipients, expected Federal savings are transitory in nature. Inclusion of these trust funds, and their surpluses, in the unified budget only makes it appear that these revenues contribute to real deficit reduction. Enactment of mandatory coverage will achieve dubious Federal savings but at substantial immediate cost to state and local governments and their employees.

Given the potential impact of these proposals on the Commonwealth, I greatly appreciate the leadership role you have taken on this issue. I urge you to continue your strong opposition to further legislative attempts aimed at expanding medicare/social security coverage to state and local employees.

Sincerely,

Mike

Michael S. Dukakis
Governor

MSD:MN/dw

Attachments

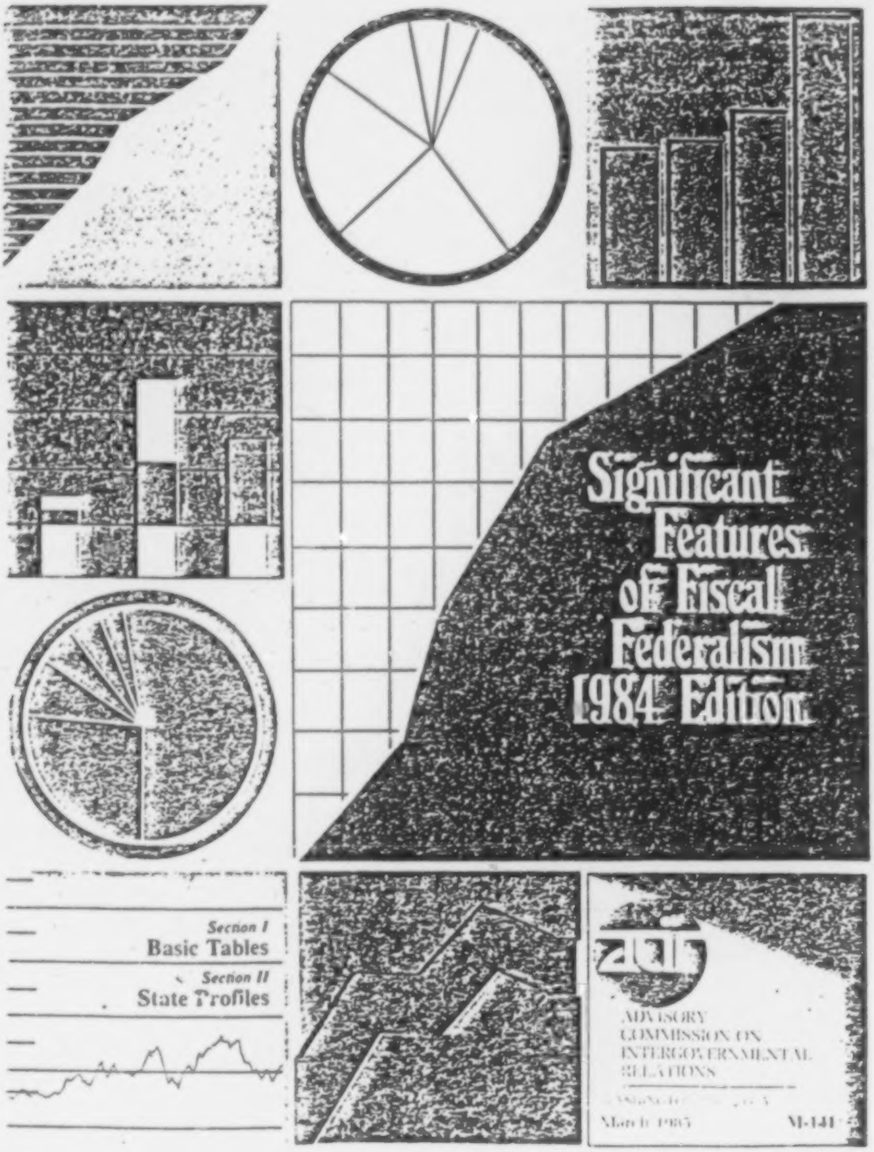
MEDICARE AND SOCIAL SECURITY

Impact of adding all Massachusetts State and Local Employees to Medicare effective January 1, 1986 and all new State and Local Employees to Social Security effective January 1, 1986.*

	1986**	1987	1988	1989	1990	TOTAL
STATE						
Medicare	22 M	23 M	24 M	25 M	26 M	120 M
Social Security	3 M	11 M	22 M	35 M	46 M	117 M
Total	25 M	34 M	46 M	60 M	72 M	237 M
LOCAL						
Medicare	51 M	53 M	55 M	58 M	61 M	278 M
Social Security	4 M	14 M	25 M	37 M	51 M	131 M
Total	55 M	67 M	80 M	95 M	112 M	409 M
TOTAL						
Medicare	73 M	76 M	79 M	83 M	87 M	398 M
Social Security	7 M	25 M	47 M	72 M	97 M	248 M
TOTAL	80 M	101 M	126 M	155 M	184 M	646 M

*Prepared by Governor's Office of Federal Relations in conjunction with the Executive Office of Administration and Finance. The payroll numbers used in calculating these costs are based on actuarial estimates prepared by the Massachusetts Retirement Law Commission.

**Costs are calculated on calendar year basis.



Significant Features of Fiscal Federalism 1984 Edition

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INTERGOVERNMENTAL
RELATIONS

WASHINGTON, D.C.

March 1985 M-141

TABLE 92--STATE FISCAL DISCIPLINE MECHANISMS

STATE	TAX AND EXPENDITURE LIMITATIONS	BALANCED BUDGET REQUIREMENT	REQUIRE SUPER-MAJORITY VOTE TO PASS TAX	INDEX INCOME TAX	GUBERNATORIAL LINE-ITEM VETO	FISCAL NOTE REVIEW PROCEDURE	PROGRAM EVALUATION & SUNSET	"RAINY DAY" FUNDS
TOTAL	18	49	7	10	43	41	29	26
New England								
Connecticut		X			X	X	X	X
Maine		X		X			X	
Massachusetts		X			X	X		
New Hampshire		X				X	X	
Rhode Island	X	X				X	X	X
Vermont							X	
Mideast								
Delaware		X	X		X		X	X
Maryland		X			X	X	X	
New Jersey		X			X	X		
New York		X			X			X
Pennsylvania		X			X	X	X	
Great Lakes								
Illinois		X			X	X	X	
Indiana		X				X	X	X
Michigan	X	X			X	X		X
Ohio		X			X	X		X
Wisconsin		X		X	X	X		
Plains								
Iowa		X		X	X	X		X
Kansas		X			X	X	X	
Minnesota		X		X	X			X
Missouri	X	X			X	X		
Nebraska		X			X	X		X
North Dakota		X			X			
South Dakota		X	X		X	X		
Southeast								
Alabama		X			X	X	X	
Arkansas		X	X		X	X		
Florida		X	X		X	X		X
Georgia		X			X	X	X	X
Kentucky		X			X	X		X
Louisiana	X	X	X		X	X	X	
Mississippi		X	X		X	X		X
North Carolina		X				X		
South Carolina	X	X		X	X	X	X	X
Tennessee	X	X			X	X	X	X
Virginia		X			X	X		X
West Virginia		X			X	X	X	
Southwest								
Arizona	X	X		X	X	X	X	
New Mexico		X			X	X	X	X
Oklahoma		X			X		X	
Texas	X	X			X	X	X	
Rocky Mountain								
Colorado	X	X		X	X	X	X	X
Idaho	X	X			X	X		X
Montana	X	X		X	X	X	X	
Utah	X	X			X	X	X	
Wyoming		X			X	X	X	X
Far West								
California	X	X	X	X	X	X		X
Nevada	X	X				X		
Oregon	X	X		X	X	X	X	
Washington	X	X			X	X	X	X
Alaska	X	X			X		X	X
Hawaii	X	X			X		X	

NOTE: In several cases, the measure has been adopted by a state, but not yet implemented.

SOURCE: 1984 ACIR Survey of Executive and Legislative Fiscal Officers.

TABLE 93—RESTRICTIONS ON STATE AND LOCAL GOVERNMENT TAX AND EXPENDITURE POWERS (OCTOBER 1984)

States	State Imposed Limits on Local Governments							
	Overall Property Tax Rate Limit	Specific Property Tax Rate Limit	Property Tax Levy Limit	General Revenue Limit	General Expenditure Limit	Limits on Assessment Increases	Full Disclosure	Limits on State Governments
Total Number	12	31	21	6	6	7	13	18
Alabama	CMS***	CMS*						
Alaska	CMS**		CM**					Const.***
Arizona			CM***		CMS***	CMS***		Const.***
Arkansas		CMS*	CMS***1/					
California	CMS***				CMS***	CMS***		Const.***
Colorado		CS*	CM*		S**		CMS***	Stat.**
Connecticut								
Delaware		S**	C***1/					
Dist. of Col.								
Florida	CM***	CMS*					CMS**	
Georgia		S*						
Hawaii							C**	Const.***
Idaho		CMS*	CMS***					Stat.***
Illinois		CMS*					CMS***	
Indiana			CMS***					
Iowa		CM*				CMS***	CMS*	
Kansas		3/	CM**		S**			
Kentucky	CMS*	CMS***					CMS***	
Louisiana		CMS**	CMS***1/					Stat.***
Maine								
Maryland				CM***		CM**	CM**	
Massachusetts			CMS***					
Michigan	CS*	M*	CMS***				CMS***	Const.***
Minnesota		S*	CMS**	M**	S**			
Mississippi		CMS*	CMS***	CMS***				
Missouri		CMS*		CMS***				Const.***
Montana		CMS*					CMS**	Stat.***
Nebraska		CMS*		CMS***5/				
Nevada	CMS*	S*	CM**					Stat.***
New Hampshire								
New Jersey			C**		MS**			
New Mexico	CMS*	CMS**	CMS***			CMS**		
New York		CMS*				CM***2/		
North Carolina		CM**						
North Dakota			CMS***					
Ohio	CMS*		CMS**1/					
Oklahoma	CMS*	CMS*						
Oregon			CMS*			CMS***		Stat.***
Pennsylvania		CMS*-/						
Rhode Island			M				M	Stat.**
South Carolina								Stat.***
South Dakota		CMS*						
Tennessee							CMS***	Const.***
Texas		CMS**					CMS***	Const.***
Utah		CMS*						Stat.***
Vermont								
Virginia							CM**	
Washington	CMS**	CMS**	CMS**	S**				Stat.***
West Virginia	CMS*	CMS*						
Wisconsin		CMS*						
Wyoming		CMS*						

C—County M—Municipal S—School District *--Enacted before 1970 **--1970 to 1977 ***—1978 and after
Const.—Constitutional Stat.--Statutory

See notes on next page.

1/ Limits follow reassessment. 2/ Applicable to only New York City and Nassau County. 3/ Only for selected districts (Fire, Library, Cemetery, etc.) -/ Jurisdictions with home rule charters are not subject to limits. 5/ Expires Decembe 31, 1984.

Source: ACIR staff calculations based on surveys of state revenue departments.

U.S. Advisory Commission on Intergovernmental Relations

TABLE 93--RESTRICTIONS ON STATE AND LOCAL GOVERNMENT TAX AND EXPENDITURE POWERS (OCTOBER 1984) (Continued)

Explanation of Column Headings

Overall Property Tax Rate Limit: refers to the maximum rate that may be applied against the assessed value of property without a vote of the local electorate. The rate is usually expressed as millions per dollar of assessed value. The overall limit refers to the aggregate tax rate of all local governments--municipal, county, school districts, and special districts (if applicable).

Specific Property Tax Rate Limit: same as above, except the specific rate limit refers to limits on individual types of local governments (i.e., separate limits for cities, counties, etc.) or limits on narrowly defined services (excluding debt).

Property Tax Levy Limit: refers to the maximum revenue that a jurisdiction can raise from the property tax. This is typically enacted as an allowed annual percentage increase in the property tax levy.

General Revenue Limit: refers to the total amount of revenue, both from property and nonproperty tax sources, that a local government is allowed to collect during a fiscal year.

General Expenditure Limit: refers to the maximum amount that a jurisdiction can either appropriate or spend during a fiscal year. This is usually legislated as an allowed annual percentage increase in operating expenses.

Limits on Assessment Increases: by limiting increases in assessments, taxpayers are protected from escalating tax bills caused by appreciating property values. This forces local governments to increase tax rates for needed additional revenue, rather than rely on this automatic revenue windfall caused by rising property values.

Full Disclosure or Truth-in-Property Taxation: refers to a procedure designed to promote public discussion and political accountability requiring local governing bodies to advertise and hold public hearings on proposed tax rate increases.

The **Chairman**. Senator Durenberger.

Senator **Durenberger**. No questions.

The **Chairman**. Senator Long.

Senator **Long**. I believe you touched on the same thing that I mentioned before you started testifying, Senator Kerry. Did you hear my statement about taxing the State governments to try to solve our problem?

Senator **Kerry**. Yes, I did.

Senator **Long**. I think that's what we are talking about here. There is a proposal—it has not been entirely agreed to by the House committee, but the proposal is to include State and local government employees for the cash benefit programs as well as for medical care, to take the young people out of the State programs and put them under the Federal program. The old ones would be left the way they were, if I understand it.

Now that's a fine kettle of fish. You need to tax your young people in order to find the money to look after the old ones.

If you take the young people out, who is going to pay for the old ones? There are proposals out there that say, well, we will take all those who are a real good risk out of the State program and put them in the Federal program. Over time we will take all the payers out of the State program, put them in the Federal program, and leave the States with all the people who are getting the benefits.

No State can finance itself very long that way. And I take it that's part of what you are complaining about here.

I want to say to you, Senator Kerry, that the principle involved here is something where this committee has played the part of consistency, principle and honor down through the years. I don't see that our fiscal situation is so desperate that we can't finance ourselves and still conform to certain principles of government that started when the Union was first founded.

Louisiana was not a part of the original Union, but several of those basic ideas were very good and deserve to be respected even now. You can be sure that you have my support in trying to stay by certain standards that have served this country very well for 200 years.

Senator **Kerry**. Well, I thank you for that comment.

If I could just add that there is a shell game aspect to this; not an entirety, but certainly a certain portion because Social Security is being taken off of budget, as we know, by 1993. There is a move by some to take it off sooner.

But whether you take it off or don't take it off, the hard reality is that since it's dedicated funding, it is not really a reduction in the deficit except to the degree that interest paid on notes through the purchase of funds represents a certain amount of income that goes against general revenue.

In point of fact, it's really insignificant in terms of it's steps to reduce the deficit. But, obviously, very significant in terms of the burden on the States.

Senator **Long**. Even more important to me than that is the fact that once you start going down this road of trying to solve your problem by taxing the States and the local governments, you are just begging for trouble.

The Federal Government has done a great job of defending itself against taxation by those State and local governments. I'm not complaining about that. But we ought to be willing to see both sides of that coin.

If they are not going to tax us, we shouldn't be taxing them. And people like you and me who are elected at the State level instead of the Federal level, we ought to respect that principle.

My prediction is that once you start down that road, eventually you are going to have to retrace every step of that because the public is going to say it's wrong. So why start that way in the first instance?

Thank you.

The CHAIRMAN. Senator Mitchell.

Senator MITCHELL. I have no questions, Mr. Chairman. I merely want to commend Senator Kerry for a very thoughtful and persuasive statement.

Senator KERRY. Thank you very much.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. No questions.

The CHAIRMAN. Senator Bentsen.

Senator BENTSEN. No questions.

Senator KERRY. Thank you.

The CHAIRMAN. Thank you very much, Senator.

Our next witness will be Mikel Rollyson, the Tax Legislative Counsel for the Department of the Treasury, appearing here instead of Deputy Assistant Secretary Mentz.

I will encourage all of the witnesses to put their statements in the record in full and hold themselves to 5 minutes orally because I know the committee has questions.

Go right ahead, Mr. Rollyson.

STATEMENT OF THE HONORABLE MIKEL M. ROLLYSON, TAX LEGISLATIVE COUNSEL, DEPARTMENT OF THE TREASURY, WASHINGTON, DC

Mr. ROLLYSON. Thank you, Mr. Chairman. Mr. Mentz unfortunately was called out of town today and could not be here.

I will keep my statement rather brief.

I'm here today to present the views of the Treasury Department on certain of the revenue initiatives included in the President's fiscal year 1986 budget proposal.

I will discuss whether the temporary increase in the cigarette excise tax should be extended; whether the deposit schedule for Social Security taxes of State and local governments should be conformed to the private sector deposit schedule; and whether the industry pensions paid in addition to Social Security benefits under railroad retirement pensions should be taxed in the same manner as all other private industry pensions.

Other administration officials here today and some who will be appearing before you this afternoon and tomorrow will discuss other revenue initiatives in the President's budget, and also in the Ways and Means bill.

The administration generally is opposed to any form of Federal tax increase at this time. Fees imposed for the use of Federal Government property or services, however, are an appropriate means of compensating the Federal Government for the expenses incurred in making such property or services available to the public; and, thus, other administration witnesses will be testifying this morning in support of certain user fees.

First, let me discuss the extension of the cigarette excise tax.

The current tax rate of $.16 per pack of 20 cigarettes is scheduled to be reduced to $.08 per pack on October 1, 1985.

Our position is that the excise tax should be allowed to decline to $.08 per pack on October 1 in accordance with current law.

The excise taxes on tobacco products discriminate against consumers who prefer to spend a portion of their incomes on these products. Moreover, the excise taxes on tobacco are regressive because low income individuals spend a larger percentage of their income on these products than wealthier individuals.

According to the 1980–1981 consumer expenditure survey diary data, the population with the lowest income spent six times as much of their income on tobacco products as did the population with the highest income.

In addition, State and local governments currently impose excise taxes on cigarettes. In 1984, State and local revenues from these taxes equaled $4.3 billion.

To the extent that higher Federal taxes on tobacco products reduced tobacco consumption, they could restrict the ability of these State and local governments to raise revenues from these sources. As the cigarette excise tax is a relatively easy tax to administer, we regard it as appropriate that most of the revenue from the excise taxation of cigarettes be collected by the States.

The Treasury Department, thus, favors the scheduled termination of the temporary increase in the excise taxes on tobacco products on September 30, 1985.

Now, let me address the State and local deposit of Social Security payroll taxes.

Under present law, States that provide Social Security coverage for their employees and the employees of their political subdivisions are required to pay Social Security contributions directly to the Social Security Trust Fund within approximately 2 weeks following the semimonthly period in which the covered wages were paid.

The administration has submitted legislation to implement the revenue initiative in the President's budget that would treat Social Security contributions of public employees as Federal Insurance Contributions Act taxes, as is the case in Social Security contributions of private employers and the Federal Government.

This would thereby transfer the administration and collection of these contributions from the Department of Health and Human Services to the Internal Revenue Service.

Under the proposed legislation, the States, their political subdivisions and intrastate instrumentalities would individually remit their Social Security contributions in the form of FICA taxes to the IRS along with the Federal income taxes they currently withhold, and States would no longer be liable for deposits of substate entities.

The deposit schedule would be conformed to the private sector rules over a 2-year phase-in period. The States and their political subdivisions would be subject to the same interest charges and penalties on late payments, and would have the same rights to administrative appeal and judicial review under the Internal Revenue Code, as do private sector employers.

The Treasury Department favors treating Social Security contributions of public employers as FICA taxes. Conforming the State and local government deposit schedule to the deposit schedule of the private sector and placing the responsibility for the collection of all Social Security contributions with the Internal Revenue Service will lead to earlier and more efficient collection of these contributions.

Finally, let me address the taxation of certain railroad retirement benefits.

Under present law, certain railroad retirement system benefits computed by using the Social Security benefit formula, known as tier 1 benefits, are subject to Federal income tax in the same manner as Social Security benefits. Tier 1 benefits, however, may be available at an earlier age or in amounts in excess of benefits payable under the Social Security system.

Under the President's budget proposal, tier 1 benefits that equal the Social Security benefits to which the individual would have been entitled if all the individual's employment on which the annuity is based had been employment for Social Security benefit purposes would continue to be taxed the same as Social Security benefits.

Other tier 1 benefits would be taxed under the rules that apply to all other payments under the railroad retirement system; that is, they would be subject to Federal income tax to the extent payments received——

The CHAIRMAN. Mr. Rollyson, let me interrupt you and ask you not to read the statement verbatim. We have read it. There are only three of us here, and we would rather have you summarize it.

Mr. ROLLYSON. Fine.

The essence of the railroad retirement benefit proposal is simply that we will tax amounts equivalent to Social Security benefits as Social Security benefits are taxed. We will tax all other amounts as private pensions would be taxed.

I'd be glad to respond to your questions, Mr. Chairman.

The CHAIRMAN. I have some questions of some later witnesses involving customs, but as the Deputy Commissioner for Customs is going to be here, I will hold on that until he testifies.

Your statement is quite straightforward and quite easy to understand. I have no questions.

Senator Mitchell, Senator Baucus.

Senator MITCHELL. Mr. Chairman, I do have a couple of questions, if I might.

The CHAIRMAN. Go ahead.

Senator MITCHELL. Mr. Rollyson, it's my understanding that extending the cigarette tax at the current level would produce revenues of approximately $5 billion over the next 3 years. Is that your understanding as well?

Mr. ROLLYSON. That's correct, Senator.

Senator MITCHELL. All right. In that event, I think it raises serious questions about the administration's concern for the deficit for you to propose permitting that tax to be reduced as scheduled.

I guess it's semantics whether it is a tax increase, to continue a tax at its current level on the one hand or permit a schedule decline to occur on the other. Not a day goes by when we don't read about public concern for the deficit. The administration makes a lot of statements about it, but here you are, in effect, saying let's surrender $5 billion in revenue over the next 3 years that it is now being received.

Do you not feel at least a twinge of inconsistency between the repeated public statements about the need to deal with the deficit by the administration and your position on this issue?

Mr. ROLLYSON. There is no doubt that extension of this scheduled decrease or permitting it to go into effect is not the easiest question that one must address.

But we do believe that not permitting the scheduled decrease to go into effect would be essentially equivalent to a tax increase, and the administration has consistently opposed any broad-based tax increases, as you are well aware, and this certainly is both a broad-based tax and a very regressive tax. And, therefore, we do oppose it.

Senator MITCHELL. I really must say that the administration's position strikes me as ideology first and foremost and damn the consequences. No matter what happens to the deficit, no matter what happens to the economy, we can't have a tax increase, period.

And I have to note some irony in your concern, both in your written statement and in your oral remarks about the regressive nature of the tax.

The President supported and signed into law, did he not, the temporary increase that we are now talking about?

Mr. ROLLYSON. Yes; he did.

Senator MITCHELL. And he didn't say anything about that being regressive at that time, did he?

Mr. ROLLYSON. I don't recall that statement being made, Senator.

Senator MITCHELL. The President supported and signed legislation maintaining the level of the telephone excise tax at the time that occurred, did he not?

Mr. ROLLYSON. Yes; he did.

Senator MITCHELL. And neither he nor you said anything about that being regressive, did you?

Mr. ROLLYSON. Not to my knowledge, Senator.

Senator MITCHELL. The President supported and signed into law the increase in the gasoline tax, did he not?

Mr. ROLLYSON. Yes; he did.

Senator MITCHELL. And neither he nor you said anything about that being regressive, did you?

Mr. ROLLYSON. Not to my knowledge.

Senator MITCHELL. And the President proposed and supported reducing the maximum rate in the income tax law from 70 to 50 percent; he now proposes to reduce it to 35 percent, thereby compressing significantly the tax schedule and as a consequence reducing substantially the progressivity of the income tax rates, does he not?

Mr. ROLLYSON. He has, but I have to disagree with you that it, in fact, makes the tax schedule less progressive. I think the tax reform proposal, which reduces the marginal rates from 50 percent to 35 percent, has to be taken in context with the extreme number of base broadeners and closing of preferences that the administration's proposal puts forward.

I think one of the principal problems that we face today is that although the Internal Revenue Code and the rate brackets appear to be extremely progressive, taking into account the preference items. they are not progressive. And, in fact, do not operate in a progressive fashion.

Indeed, I think the proposals to eliminate those preferences and reduce rates across the board will result in a more progressive rather than a less progressive tax structure.

Senator MITCHELL. Well, of course, it's possible to eliminate the preferences and not reduce the rates to the level contemplated, isn't it?

Mr. ROLLYSON. Sure, it is.

Senator MITCHELL. So, you would accomplish what you have suggested without the necessity of reducing the schedule. Well, that's a separate issue and I won't belabor it.

I see my time is up. Mr. Chairman, I will have several questions on the recommendation to change the method of collecting State and local Social Security payroll taxes.

In the interest of time, Mr. Rollyson, I would submit those to you in writing. As you know, a great deal of concern has been expressed by State governments and I do have some reservations about this proposal.

Mr. ROLLYSON. We will respond.

Senator MITCHELL. Thank you very much, Mr. Rollyson. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Let me ask you one question, Mr. Rollyson.

The budget resolution that has been adopted calls for the Congress to come up with $15.7 billion in revenues over 3 years. Does the administration support or not support that?

Mr. ROLLYSON. It's my understanding that the administration does support the budget resolution. We do not have at this time, however, specific further revenue initiatives to put before the committee.

Senator BAUCUS. Thank you.

The CHAIRMAN. It might be helpful, before we start marking this up, so long as the administration does support it, if they would suggest to us how they would like to pick up the $15.7 billion. And these are revenues. These are not user fees.

Mr. ROLLYSON. Right.

The CHAIRMAN. These are revenues.

Could you see if you can get the administration to provide us with some specifics or suggestions as to how we get that money?

Mr. ROLLYSON. We will certainly be discussing that, Senator.

The CHAIRMAN. Thank you.

Mr. ROLLYSON. Thank you.

The CHAIRMAN. Any other questions?

[No response.]

The **Chairman**. If not, thank you, sir.

[The prepared written statement of Mr. Rollyson follows:]

STATEMENT OF
MIKEL M. ROLLYSON
TAX LEGISLATIVE COUNSEL
DEPARTMENT OF THE TREASURY

Mr. Chairman and Members of the Committee:

It is my pleasure to be here today to present the views of the Treasury Department on certain of the revenue initiatives included in the Presidents' fiscal year 1986 budget proposal. I will discuss whether the temporary increase in the cigarette excise tax should be extended, whether the deposit schedule for social security payroll taxes of state and local governments should be conformed to the private sector deposit schedule, and whether the industry pensions paid in addition to social security benefits under railroad retirement pensions should be taxed in the same manner as all other private industry pensions. Other Administrative officials will discuss other revenue initiatives proposed in the President's budget.

The Administration generally is opposed to any form of Federal tax increase at this time. Fees imposed for the use of Federal Government property or services, however, are an appropriate means of compensating the Federal Government for the expenses incurred in making such property or services available to the public, and thus other Administration witnesses will be testifying this morning in support of certain user fees.

DISCUSSION

Extension of the Cigarette Excise Tax

The current tax rate of 16 cents per pack of 20 cigarettes is scheduled to be reduced to 8 cents per pack on October 1, 1985. Our position is that the excise tax should be allowed to decline to 8 cents per pack on October 1 in accordance with current law.

Excise taxes are imposed upon cigars, cigarettes, and cigarette papers and tubes manufactured in or imported into the United States. In general, the manufacturer or importer is liable for these taxes when the products are removed from the factory or released from customs custody. The rate of tax imposed on small cigarettes (weighing no more than 3 pounds per thousand) removed from bonded premises before January 1, 1983 and after September 30, 1985 is $4 per thousand, which is equivalent to a tax of 8 cents per pack of 20 cigarettes. The rate of tax imposed on large cigarettes (weighing more than 3 pounds per thousand) is $8.40, which is equivalent to a tax rate of 16.8 cents per pack of 20 cigarettes. The Tax Equity and Fiscal Responsibility Tax Act of 1982 temporarily increased the rate of tax on small cigarettes to $8 per thousand, which is equal to a tax rate of 16 cents per pack. Similarly, the rate of tax imposed on large cigarettes was temporarily increased to $16.80 per thousand, which is equal to a tax rate of 33.6 cents per pack. These temporary increases are scheduled to expire on September 30, 1985.

Excise taxes on tobacco products discriminate against consumers who prefer to spend a portion of their incomes on these products. Moreover, the excise taxes on tobacco are regressive because low income individuals spend a larger percentage of their income on these products than wealthier individuals. According to the 1980-81 Consumer Expenditure Survey Diary Data, tobacco expenditures are 2.4 percent of income for the quintile of the population with the lowest income, but are only .4 percent of the income for the quintile of the population with the highest income.

In addition, state and local governments currently impose excise taxes on cigarettes. In 1984, state and local revenue from these taxes equaled $4.3 billion. To the extent that higher Federal taxes on tobacco products reduce tobacco consumption, they could restrict the ability of such governments to raise revenue from these sources. The cigarette excise tax is a relatively easy tax to administer, and, therefore, we regard it as appropriate that most of the revenue from the excise taxation of cigarettes is collected by the states.

In summary, the Treasury Department favors the scheduled termination of the temporary increase in the excise taxes on tobacco products on September 30, 1985.

State and Local Deposit of Social Security Payroll Taxes

Under present law, states that provide social security coverage for their employees and the employees of their political subdivisions are required to pay social security contributions attributable to such coverage directly to the Social Security Trust Fund within approximately two weeks following the semi-monthly period in which the covered wages were paid. If the state contributions are not paid timely, interest accrues at a rate of 6 percent per annum. The Secretary of Health and Human Services is responsible for ensuring that contributions are properly paid. States aggregate and deposit social security contributions on their own behalf, and on behalf of other governmental entities.

The Administration has submitted legislation to implement the revenue initiative in the President's budget that would treat the social security contributions of public employers as Federal Insurance Contributions Act (FICA) taxes -- as is the case for social security contributions of private employers and the Federal Government -- and thereby transfer the administration and collection of these contributions from the Department of Health and Human Services to the Internal Revenue Service. Under the proposed legislation, the states, their political subdivisions, and interstate instrumentalities would individually remit their social security contributions in the form of FICA taxes to the Internal Revenue Service along with the Federal income taxes they currently withhold, and states would no longer be liable for deposits of sub-state entities. The deposit schedule would be conformed to the private sector rules over a two-year phase-in period. The states and their political subdivisions would be subject to the same interest charges and penalties on late payments and would have the same rights to administrative appeal and judicial review under the Internal Revenue Code as private sector employers.

The Treasury Department favors treating social security contributions of public employers as FICA taxes. Conforming the state and local government deposit schedule to the deposit schedule of the private sector and placing the responsibility for the collection of all social security contributions with the Internal Revenue Service will lead to earlier and more efficient collection of these contributions.

Taxation of Railroad Retirement Benefits

Under present law, certain Railroad Retirement system benefits computed by using the social security benefit formula ("tier 1 benefits") are subject to Federal income tax in the same manner as social security benefits. Tier 1 benefits, however, may be available at an earlier age or in amounts in excess of benefits payable under the social security system.

Under the President's budget proposal, tier 1 benefits that equal the social security benefits to which the individual would have been entitled if all of the individual's employment on which the annuity is based had been employment for social security benefit purposes would continue to be taxed in the same manner as social security benefits. Other tier 1 benefits would be taxed under the rules that apply to all other payments under the Railroad Retirement system, i.e., they would be subject to Federal income tax to the extent payments received exceed the amount of the individual's previously taxed contributions to the plan. Thus, tier 1 benefits that are in excess of the social security benefits to which an individual would be entitled, or are payable at an age earlier than social security benefits, would be subject to tax in the same manner as all other payments under the Railroad Retirement system.

The Treasury Department supports this proposal. Beneficiaries of the Railroad Retirement system should receive the favorable tax treatment afforded social security benefits to the extent their tier 1 benefits are equivalent to what the individual would have received if the individual's employment under the Railroad Retirement system had been covered employment for social security purposes. Conversely, the portion of tier 1 benefits that is not equivalent to a social security benefit and, therefore, is essentially the same as a private pension benefit, should not be eligible for the special tax treatment accorded social security benefits, but should be taxed like all other private pensions.

* * *

This concludes my prepared remarks. I would be happy to respond to your questions.

The CHAIRMAN. Next we will take Kathleen Utgoff, the Executive Director of the Pension Benefit Guaranty Corporation.

And if I might ask you to do the same as I asked your predecessor, to put your entire statement in the record and abbreviate it within our 5-minute time limit.

STATEMENT OF KATHLEEN P. UTGOFF, EXECUTIVE DIRECTOR, PENSION BENEFIT GUARANTY CORPORATION, WASHINGTON, DC

Ms. UTGOFF. Thank you, Mr. Chairman. I will do that.

The CHAIRMAN. Thank you.

Ms. UTGOFF. I'm pleased to appear before you today to testify on behalf of the administration in support of an increase in the premium for the Single Employer Pension Insurance Program, and in support of related reforms in the program.

This important insurance program is a safety net for 30 million workers and retirees covered by private defined benefit pension plans. As of the end of fiscal year 1984, the PBGC was responsible for payment of benefits to about 149,000 current and future retirees in approximately 1,100 terminated plans.

Unfortunately, the program does not have sufficient assets to cover its obligations. As of September 30, 1984, only 70 percent of the program liabilities were funded by assets.

The fiscal 1984 year end deficit of $462 million continues to grow. On July 26 of this year, the termination of the Allis-Chalmers plan alone increased the PBGC deficit by over $150 million.

To correct this situation, the administration has proposed a premium increase from $2.60 to $7.50 per participant per year effective January 1, 1985.

If the effective date of the increase were delayed 1 year to January 1, 1986, the equivalent amount needed will be $8.10.

Now, why does the PBGC need a premium increase?

The only reason is that claims against the PBGC have increased dramatically since the Corporation was created. In the first 4 years of the insurance program, plan terminations increased PBGC liabilities by an average of $35 million a year.

In the next 3 years, the average was $68 million. And in the most recent 3 years, about $163 million.

Projecting our experience into the future, we estimate an average increase in liabilities to over $185 million a year over the next 15 years.

In order to fund these new liabilities as they are incurred requires a premium of about $5. The additional premium needed to erase the deficit that has already accumulated, assuming a 15-year amortization period, is about $1.50.

Finally, administrative expenses add another dollar for a total of $7.50.

The GAO has approved the projection method and has testified to the Congress that a premium of $7.50 is the lowest reasonable amount.

The PBGC is now adding to the Federal deficit. This situation will worsen very rapidly unless a premium increase is enacted. Without an increase, the program's asset-to-liability ratio will decline from last year's figure of 70 percent to 54 percent at the end of fiscal year 1989. The deficit will rise to at least $1.3 billion by the end of 1989, and to $5.5 billion by the end of 1999.

Failure to enact a premium increase will put the program at risk in the not too distant future and create pressure for funding from general revenues.

While the requested increase is large in percentage terms, it is modest in absolute and relative terms. For example, it is about one=tenth of 1 percent of the typical employer's annual payment for employee benefits.

Now, let me turn to our proposed reforms.

Our proposed legislative reforms for the Single Employer Program will help protect the insurance program so that it can continue to pay benefits when they are needed. These reforms will reduce abusive claims against the insurance system in several ways.

First, about 20 percent of our net claims have come from ongoing companies that are not in any type of bankruptcy proceeding. The reforms will limit the circumstances under which the PBGC would accept the termination of an underfunded plan to cases in which the sponsor is clearly in financial distress. They will also increase our recovery from companies that terminate an underfunded plan and later become profitable. This will be done by providing the PBGC a limited interest in future profits of companies that do recover.

About 21 percent of the program's deficit is due to the granting of minimum funding waivers. The reforms will help plans and the PBGC collect on large unpaid or waived contributions by creating a lien in favor of the plan for these amounts. The lien will reduce the incentive to seek funding waivers. If a waiver is obtained, a secured claim will improve the prospects for collection in bankruptcy proceedings which otherwise are very poor.

The lien will not arise in situations where it would be unnecessary or counterproductive and small businesses will not be affected.

Finally, we are requesting that an express provision be added to the law to protect the program from abusive losses caused by transfers of unfunded pension benefits from stronger to weaker companies that subsequently fail.

This proposed clarification of current law will not disrupt normal business practices.

Mr. Chairman, let me conclude by saying that the PBGC Insurance Program is in desperate need of a premium increase and fundamental reforms in order to assure that we will be able to meet the promises that Congress made when the PBGC was created.

We look forward to working with Congress in achieving that goal.

Thank you, Mr. Chairman, for the opportunity to testify. Now I will be happy to answer any questions that you have.

[The prepared written statement of Ms. Utgoff follows:]

TESTIMONY OF KATHLEEN P. UTGOFF
EXECUTIVE DIRECTOR
PENSION BENEFIT GUARANTY CORPORATION

Mr. Chairman:

I am pleased to appear before you today to testify on behalf of the Administration in support of an increase in the premium for single-employer plan termination insurance and related program reforms. The Administration has requested an increase in the premium to $7.50 per participant per year, effective January 1, 1985. If the effective date of the increase were delayed one year, to January 1, 1986, the equivalent amount needed would be $8.10.

In 1974, as a part of the Employee Retirement Income Security Act (ERISA), the Congress created a much needed insurance program to guarantee payment of vested benefits in terminating defined benefit plans that do not have sufficient assets to provide the promised benefits. Two insurance funds were created for this basic benefits guarantee program, one for single-employer plans and one for multiemployer plans. My testimony today addresses only the single-employer program. The Congress legislated changes in the multiemployer program, including premiums, in September, 1980, and no further premium adjustment is needed in that program at this time.

In the single-employer program, as of the end of FY 1984, the PBGC was responsible for payment of benefits to about 149,000 current and future retirees and beneficiaries in approximately 1,100 terminated plans. As of September 30, 1984, the program had liabilities of $1.5 billion and assets of $1.1 billion, leaving an accumulated deficit of $462 million. Since that time our deficit has grown. On July 26, 1985, the termination of the Allis-Chalmers plan alone increased the PBGC deficit by over $150 million.

To correct this situation, the Administration has proposed a premium increase and program reforms that would help to eliminate unintended and inappropriate claims against the program. I will first address the premium needs and then briefly discuss the proposed legislative reforms.

Single-Employer Claims History: Escalating Annual Net Claims

The net claims from terminated plans have increased dramatically. In the first four years of the insurance program (July 1, 1974 - September 30, 1978), the average annual net claim was about $35 million; in the next three years (October 1, 1978 - September 30, 1981), about $68 million; and in the most recent three years (October 1, 1981 - September 30, 1984), about $163 million.

A premium study conducted by the PBGC in May 1982 showed that a $6.00 premium would be needed beginning in January 1983 to meet a deficit elimination target of December 31, 1987, that was contained in the 1977 premium request. Unfortunately, no action was taken on that or subsequent requests. Because the premium has remained at $2.60 our deficit has grown since 1977 and consequently, the premium required to eliminate it has also grown.

Our original request was for $6.00. Our request was raised to $7.00 in 1984 and now we are requesting $7.50 for 1985. The 1986 equivalent is $8.10.

Basis for $7.50 Premium Request

The $7.50 premium request includes about $5.00 to pay projected future claims as they are incurred, $1.50 to retire the accumulated deficit over a 15-year period and $1.00 for administrative expenses.

These figures assume a plateau of 30.6 million participants in the single-employer program during FY 1985, and a gradual return by FY 1989 to the historical average annual increase of 1.1 million, plus an additional million in FY 1986 due to the Retirement Equity Act.

The projections underlying the premium request were based on past trends, with the exception that the abnormally bad experience of 1982 and 1983 and the abnormally good experience of 1984 were spread uniformly over the prior years.

This projection method, which was approved by the GAO, results in average annual net claims of $185 million over the next 15 years. This figure does not include an explicit contingency reserve for extraordinarily large claims. At the same time, the 15-year projection period allows some flexibility for large claims in individual years.

The request assumes that net claims will be funded in the year incurred consistent with the immediate full funding policy adopted by the Congress in its approval of a premium increase in 1977.

Deficit Amortization. The current request would amortize the existing deficit of $462 million over 15 years, which is the longest period that we consider responsible under the circumstances. While the program is not in any immediate danger of being unable to pay benefits when due, cash flow in the single-employer program turned negative for the first time in FY 1984. Beginning in early FY 1985, the PBGC for the first time began adding to the size of the Federal deficit. This situation will worsen very rapidly unless a premium increase is enacted.

Administrative expenses. The PBGC projects that it can continue to hold administrative expenses at the current level of about $1.00 per participant.

Urgency of Request

While the requested increase is large in percentage terms, it is a modest figure both in absolute terms and relative to other labor costs. For example, it is about 1/10 of 1 percent of a typical employer's annual payment for employee benefits. Without the higher premium, however, the consequences to the insurance program could become catastrophic. The most likely forecast shows a decline in the program's asset-to-liability ratio to 54 percent at the end of FY 1989 from 70 percent at the end of FY 1984. Without a premium increase there will be an increase in the deficit to $1.3 billion by the end of 1989 and to $5.5 billion by the end of 1999. Therefore, failure to act would put the program at risk in the not too distant future and would create pressure for general revenue funding. In addition, failure to act will only compound the problem and serve to increase the premium amount needed to insure the financial integrity of the single-employer insurance program.

PROGRAM REFORMS

The President's budget request contains a request for legislative program reforms for the single-employer program as well as a premium increase. The reforms will limit the circumstances under which the PBGC would accept an insufficient termination to cases of sponsor financial distress. They will also increase the liability for companies that terminate an underfunded plan and then successfully emerge from a financial crisis by providing the PBGC an interest in the future profits of an ongoing sponsor for a stated period. The reforms also will help plans and the PBGC collect on large unpaid or waived contributions by creating a lien in favor of the plan for those amounts. The lien will not arise in situations where it would be unnecessary or counter-productive.

In addition, we are requesting that an express provision be added to the law to clarify that ERISA prohibits abusive shifts of unfunded benefits to the insurance program through transfers from stronger to weaker companies that subsequently fail. The proposed provision will protect the program from losses due to such abusive transfers; it will not disrupt normal business transactions.

Although it is impossible to put a price tag on the reforms, it is clear that without them the program costs will be higher. For example, under current law, about 20 percent of net claims have come from ongoing companies that are not in any type of bankruptcy proceeding. Without the reforms, companies that can afford to continue their plans may find it financially advantageous to terminate them because of the insurance program. Thus while savings from the reforms cannot be estimated with precision, it is clear that they sharply reduce the incentive for and possibility of unwarranted claims against the insurance fund.

Similarly, the minimum funding lien provision will reduce the incentive for sponsors to borrow from a plan by obtaining funding waivers, and provide a means for plans to collect more on a claim for unpaid contributions in bankruptcy. The lien provision should reduce PBGC's net claims but, again, a dollar figure cannot be estimated.

Conclusion

In summary, the PBGC insurance program is in desperate need of a premium increase and fundamental reforms, in order to assure that we will be able to meet the promises that Congress made when the program was created. In addition, passage of the previously mentioned legislative reforms will significantly reduce the need for any future premium increases. We look forward to working with the Congress in addressing this important matter.

Thank you, Mr. Chairman, for the opportunity to testify today. I will be happy to answer any questions you and the Committee members may have.

The CHAIRMAN. This is the first time you have appeared before us, isn't it?

Ms. UTGOFF. Yes.

The CHAIRMAN. Good job.

You know what the Ways and Means Committee did. They included a 1989 sunset in their bill, as I recall, and no reforms at all.

Ms. UTGOFF. Yes.

The CHAIRMAN. Do you want to comment on it?

Ms. UTGOFF. Yes; I think that the reforms are a crucial part of a proposal to get the PBGC on a sound financial basis. Passing the premium increase without the reforms, I believe, is like fixing a leaky bathtub by just turning up the faucet. You can do that by increasing the inflow as much as the outflow, but it's not a good use of resources.

The CHAIRMAN. What do you think about the sunset? Assuming we made the reforms, what do you think about the sunset?

Ms. UTGOFF. Well, this proposed reform is a long-term plan. It's based on a 15-year amortization period. And we have very fluctuating claims so that a 3-year period is just too short to be able to achieve the objective of this proposal, which is long-term financial stability.

The CHAIRMAN. Senator Mitchell.

Senator MITCHELL. No questions, Mr. Chairman.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Good job. We are glad to have you with us.

Ms. UTGOFF. Thank you.

Senator BAUCUS. Thank you.

The CHAIRMAN. Now, if we might have Alfred DeAngelus, the Deputy Commissioner of the U.S. Customs Service.

Your entire statement, Mr. DeAngelus, will be in the record, and if you could abbreviate it as Ms. Utgoff did, I would appreciate it.

STATEMENT OF ALFRED R. DeANGELUS, DEPUTY COMMISSIONER, U.S. CUSTOMS SERVICE, WASHINGTON, DC

Mr. DEANGELUS. Thank you, Mr. Chairman.

I appreciate the opportunity to discuss title VIII of Senate bill 1567, which would impose fees on vessels and cargo using U.S. harbors and ports and the administration's proposals for recovery of costs for providing Customs' services.

As you know, Mr. Chairman, Senate 1567, the Water Resources Development Act of 1985, incorporates the General Water Resource Project cost sharing concepts that you and other Senate leaders have discussed and that have been agreed upon by the administration.

The basic principle is that justified water projects would be initiated once legislation providing for enhanced non-Federal cost sharing is enacted. That is, in the future, projects would be constructed and maintained from new sources of revenue to help alleviate the deficit problem.

Examples of this enhanced cost sharing are reflected in the provisions of title VIII that would increase the existing inland fuel tax paid by users of our inland waterways, and make available the proceeds of the tax to construct highly productive new work on the inland system.

Title VIII would also recover from the users of our Nation's ports a significant share of the cost of the Army Corps of Engineers to operate and maintain the harbors and channels serving these ports.

Title VIII would impose three new fees on the use of U.S. harbors, ports, and channels and on the use of Great Lakes navigation improvement. These fees would be administered by the Customs Service.

Without going into detail, one of the fees would be an ad valorem fee of 0.04 percent, 400th of 1 percent, of the value of commercial cargo, loaded or unloaded, at U.S. harbors or channels by commercial vessel. This fee would be imposed on imports, exports and domestic cargos.

A similar fee would be imposed on cargo utilizing Great Lakes navigation improvements maintained or operated by the United States, exclusive of the St. Lawrence Seaway.

The third fee, based on vessel tonnage, would be imposed on commercial vessels using a U.S. harbor, channel, or Great Lakes navigation improvement. Again, exclusive of the St. Lawrence Seaway, for purposes not directly related to the transportation or loading or unloading of commercial cargo, such as repairs, bunkering, and the like.

The administration and the Department of the Treasury strongly support the intent of title VIII of S. 1567. And, in particular, the ad valorem basis of the fees imposed on cargo.

However, from technical and administrative perspectives, title VIII as drafted presents the Customs Service with problems in implementing an effective and efficient mechanism by which to assess, collect and enforce fees.

We also believe that title VI of the bill, which defines many of the terms used as a basis for the fees imposed by title VIII, requires clarification. While a few of these are of particular concern to Customs, most fall within the expertise of the Department of Transportation and the Department of the Army.

A working group composed of several Federal agencies has been analyzing the provisions of S. 1567 for many weeks. This effort has resulted in a number of administration technical amendments to the bill that we believe are necessary in order to effectively and efficiently implement the fee provision.

These administration-proposed amendments are attached to my formal statement. In addition, we have several concerns with other titles of the bill, and would advise the appropriate committees of the Congress accordingly.

With regard to Customs Service—fees for customs services, the concept of user or processing fees is not a new one within the administration. The proposed customs fees are in consonance with the belief that those who benefit from the provision of a service by the Government are those who cause the need for the service to be performed; should bear the cost of the provision of those services.

Before I go further with discussion of the proposal, I would like to put the proposal in terms of Customs perspective.

Customs has faced a continually increasing workload over the past 10 years. The number of passengers arriving by air has risen 88 percent from 18 million to 33 million passengers. The number of passengers arriving by sea has grown 65 percent, from 2.5 million to 4 million passengers. Land border crossings have risen from 250 million to 260 million. The normal of formal entries has grown from 3.3 million to 6.8 million, an increase of 119 percent.

At the same time, the number of informal entries, those of lesser value, has risen from 2.8 million to over 5 million.

Revenue collected by customs has grown 180 percent from $5 billion to nearly $14 billion. And the value of imports has increased 215 percent from $114 billion to $358 billion.

The workload increase has been even more dramatic in Customs' larger locations, such as Miami, New York, and Los Angeles. During the same period of time, Customs' total resources have grown by three-tenths of 1 percent.

The proposals are an extension of current fees for special services, such as nonduty hour inspection, vessel boarding and entry processing, compensation for requested travel or special inspectional services, an inspection at a location other than a port of entry.

The user fees——

The CHAIRMAN. I will have to ask you to conclude.

Mr. DEANGELUS. All right. Thank you, Mr. Chairman.

I would like to conclude by stating that Customs has been presented with many demands for increased services over the past years, and that these services are generally requested by special select groups, interested groups. And we believe that the proposal of these fees are fair and equitable and focus the charge of the fees to those who benefit from the service provided.

Thank you.

[The prepared written statement of Mr. DeAngelus follows:]

STATEMENT BEFORE THE
COMMITTEE ON FINANCE
SEPTEMBER 11, 1985
ALFRED R. DE ANGELUS
DEPUTY COMMISSIONER OF CUSTOMS

Mr. Chairman, I am Alfred R. De Angelus, Deputy Commissioner of Customs. I appreciate the opportunity to discuss Title VIII of S. 1567, which would impose fees on vessels and cargoes using U.S. harbors and ports, and the Administration's proposals for the recovery of costs for providing Customs services.

S. 1567

As you know, Mr. Chairman, S. 1567 (the "Water Resources Development Act of 1985") incorporates the general water resource project cost-sharing concepts that you and other Senate leaders have discussed and that have been agreed upon by the Administration. The basic principle is that justified water projects would be initiated once legislation providing for enhanced non-Federal cost sharing is enacted; that is, in the future, projects would be constructed and maintained from new sources of revenue to help alleviate the deficit problem.

Examples of this enhanced cost sharing are reflected in the provisions of Title VIII of S. 1567 that would increase the existing inland fuel tax paid by users of our inland waterways, and make available the proceeds of the tax to construct certain highly productive new work on the inland system.

Title VIII of S. 1567 would also recover from the users of our Nation's ports a significant share of the costs of the Army Corps of Engineers to operate and maintain the harbors and channels serving these ports. Title VIII would impose three new fees on the use of U.S. harbors, ports, and channels and on the use of Great Lakes navigation improvements. These fees would be administered by the Customs Service.

Without going into detail, one of the fees would be an ad valorem fee of 0.04 percent of the value of commercial cargo loaded or unloaded at U.S. harbors or channels by a commercial vessel. This fee would be imposed on imports, exports, and domestic cargoes. A similar fee would be imposed on cargo utilizing Great Lakes navigation improvements maintained or operated by the United States (exclusive of the Saint Lawrence Seaway). The third fee, based on vessel tonnage, would be imposed on commercial vessels using a U.S. harbor, channel, or Great Lakes navigation improvement (again, exclusive of the Saint Lawrence Seaway), for purposes not directly related to the transportation or loading or unloading of commercial cargo, such as repairs, bunkering and the like.

The Administration and the Department of the Treasury strongly support the intent of Title VIII of S. 1567, and in particular the ad valorem basis of the fees imposed on cargo. However, from technical and administrative perspectives, Title VIII as drafted presents the Customs Service with problems in implementing an effective and efficient mechanism by which to assess, collect, and enforce the fees.

We also believe that Title VI of the bill, which defines many of the terms used as a basis for the fees imposed by Title VIII, requires clarification. While a few of these are of particular concern to Customs, most fall within the expertise of the Department of Transportation and the Department of the Army.

A working group composed of several Federal agencies has been analyzing the provisions of S. 1567 for many weeks. This effort has resulted in a number of Administration technical amendments to the bill that we believe are necessary in order to effectively and efficiently implement the fee provisions. These Administration amendments are attached to my formal statement. In addition, we have several concerns with other titles of the bill and will advise the appropriate committees of the Congress accordingly.

Recovery of Costs for Providing Customs Services

The concept of user, or processing, fees is not a new one within the Administration. The Customs fees are in consonance with the belief that those who benefit from the provision of a service by the Government or those who cause the need for that service to be performed should bear the costs of the provision of those services. Before I go further with a discussion of the proposal, I would like to put the proposal in terms of the Customs perspective.

Customs has faced an ever increasing workload over the past 10 years:

- The number of passengers arriving by air has risen 88% from 18 million to 33 million;
- The number of passengers arriving by sea has grown by 65% from 2.5 million to over 4 million;
- Land border crossings have risen from 250 million to 260 million;
- The number of formal entries has grown from 3.3 million to 6.8 million, a increase of 119%;
- At the same time the number of informal entries has risen from 2.8 million to over 5 million;

- Revenue collected by Customs has grown by 180% from $5 billion to nearly $14 billion;

- And the value of imports has increased 215% from $114 billion to $358 billion.

The workload increase has been even more dramatic in Customs larger locations such as Miami, New York, and Los Angeles. During the same period of time, Customs resources have grown by three tenths of one percent.

The proposals are an extension of current fees charged for special services such as non-duty hour inspection, vessel boarding and entry processing, compensation for requested travel or special inspectional services, and inspection at a location other than a port of entry.

The users of Customs services are a select group. Of the 239 million United States citizens, 96 million filed personal income tax returns last fiscal year. It is those 96 million who are paying $1.5 million per day to provide the Customs services which are utilized by the less than 10% of all citizens who have any contact with Customs in a given year. There are 500 importers or firms which account for 90% of all imported cargo and 300 brokers handled over 70%, or 9 million, of all entries. Fifteen seaports accounted for over 90% of all merchandise releases, and 9 major U.S. carriers for 1/3 of all international arrivals.

We believe that the processing fee proposal enables Customs to meet the requirements of the select group of users but at the same time relieves all taxpayers of the burden of contributing to the costs of Customs non-enforcement activities.

The underlying principles of the cost recovery proposal are:

- The costs apply only to those who benefit from Customs services or create the need for those services to be performed;
- The proposal covers only the costs of providing services and does not include enforcement initiatives from which all benefit;
- The fees are equitably calculated;
- The fees are small in terms of the overall costs to importers, common carriers, and international travelers;
- The fees are easy to collect through established revenue collection or other billing procedures;

- The General Agreement on Tariffs and Trade allows for the collection of fees to cover only the costs of providing services;

- 48 other countries charge some type of user fee which we are aware of;

- The fees are set commensurate with resources and workload requirements.

I want to stress that the Customs proposal is for a fee which covers the costs of providing services to be paid by the people who benefit from or use those services.

The proposed legislation would authorize the Secretary to set and collect fees. The fees would be established annually, with public comment, so that fluctuations in workload and resources could be considered. In accordance with sound budgetary principles, the fees would be deposited in the Treasury as miscellaneous receipts as an offset to the Department of the Treasury appropriation. In some cases this would actually reduce the cost of Customs processing. Fees will be applied uniformly in all locations so that there is no need for an increase in the bureaucracy to collect the fees. There would be a clear linkage between the fee paid and the actual service provided.

As I mentioned earlier, I believe that the fees are a small part of doing business. As an example, for a shipment arriving by sea at a West Coast port with a value of $50,000, there would be a duty of approximately $2,000, a $150 broker fee, a bill of $2,800 for sea freight, and $1,000 for inland delivery. To this $56,000 transaction, Customs would add $61 as the maximum Customs processing fee for the entry documents and $15 for in-bond documentation. The Customs fees account for point one four percent (.14%) of the total cost of the transaction.

As another example, the cheapest known international airfare, one way, is from Burlington, Vermont, to Montreal, Canada or Miami, Florida, to Freeport, Bahamas. The one way fare is $45 to which Customs would add $2 or 4.4% of the total ticket price. The proposed fee is a very small percentage of most international air travel.

During hearings before the Committee on Ways and Means, the question was raised several times about the fees violating the GATT and other international agreements. We do not believe this to be the case since the Customs fees are based on actual costs only.

I would like to briefly discuss another proposal currently under review within the Administration as another means for Customs to recover some of its costs. Customs has maintained many ports as a convenience to local communities. The result has been inefficient and ineffective utilization of resources. The Administration is reviewing a proposal, which would really be an extension of the small airport authorization, which would allow Customs to charge for maintaining a Customs presence at ports in which the activity level is below a minimum standard. The standards would be set to match those activity levels required for new ports to be granted port of entry status.

The concept under review would require the approval of the state Governor. These small ports would no longer be forced to compete with larger ports for resources and would be guaranteed that Customs services would be available when those services are required. We believe that this proposal might make good business sense for all parties concerned--the ports, Customs, and the people who benefit from the convenience of having a local port of entry.

In summary, I would like to stress again that we believe that our cost recovery proposal makes good sense for everybody concerned. The processing fees are equitable, account for only a small portion of the cost of doing business to users of Customs services, require no additional bureaucracy for their collection, are easy to collect through existing procedures, and do not violate the GATT.

I have spent my entire government career in Customs and never cease to marvel at how much things have changed in the way Customs does business but also at the way in which some things never change.

During research on a legal question, a Customs attorney found a document dated February 1, 1840, from the Secretary of the Treasury, Levi Woodbury, to all Collectors of Customs. He was directing the Collectors to find ways in which money could be saved through the closure of offices, consolidations, and personnel reductions. The reductions were necessary because of declining revenues. If there were processing fees in 1840, there would have been a link between resources and workload. Now, 145 years later, I hope we finally have the opportunity to formalize that link.

Thank you and I will be glad to answer any questions.

Administration Amendments to S. 1567

TITLE VI -- HARBOR CONSTRUCTION

1. Sec. 602(a) is amended --

(1) by inserting the word "any" immediately before the words "commercial channel"; and

(2) by striking the words "construction initiated after January 1, 1985" and inserting in lieu thereof "or commercial inland harbor construction".

2. Sec. 607(a) is amended to read as follows:

"(a) There are authorized to be appropriated out of the Harbor Maintenance Trust Fund, established pursuant to part B of title VIII of this Act, for each fiscal year such sums as provided by appropriation Acts as may be necessary to pay --

"(1) not more than 40 per centum of the eligible operations and maintenance costs assigned to commercial navigation of --

"(A) all commercial channels and harbors within the United States; and

"(B) all Great Lakes navigation improvements operated or maintained by the Secretary.

"(2) to reimburse, within 30 days after the close of a fiscal quarter, appropriations which bore all or part of the cost of assessing, collecting, and enforcing the fees imposed by title VIII during the preceding fiscal quarter. Notwithstanding any other provision of law, any reimbursement made pursuant to this paragraph shall be available for expenditure by the agency receiving such reimbursement during the fiscal year in which the reimbursement is made.".

3. Sec. 608(1) is amended to read as follows:

> "(1) 'commercial channel or harbor' shall mean any channel or harbor, or element thereof, constructed or operated or maintained, in whole or in part, by the United States, and all adjoining waters with natural depths, capable of being utilized in the transportation of commercial cargo in domestic or foreign waterborne commerce by commercial vessels, that is not considered an inland or intracoastal waterway as described in Section 206 of the Inland Waterways Revenue Act of 1978 (33 U.S.C. 1804), as amended, or a Great Lakes navigation improvement;".

4. Sec. 608 is further amended by redesignating subsections (2) through (6) as subsections (3) through (7), respectively, and inserting a new subsection (2) as follows:

> "(2) 'commercial inland harbor' shall mean any harbor or channel, or component thereof, constructed or operated or maintained, in whole or in part, by the United States, and all adjoining waters with natural depths, which is located on an inland or intracoastal waterway as described in Section 206 of the Inland Waterways Revenue Act of 1978 (33 U.S.C. 1804), as amended, and which is a separate or separable project utilized principally for the accommodation of commercial vessels and the receipt and shipment of waterborne cargoes;".

5. Sec. 608(3) (unredesignated) is amended to read as follows:

> "(3)(A) the term 'eligible operations and maintenance' shall mean all operations, maintenance, repairs and rehabilitations, including maintenance dredging reasonable necessary to maintain the nominal depth and width of any commercial channel or harbor (including any such channel or harbor located within the Great Lakes) or Great Lakes navigation improvement;
>
> "(B) for purposes of subparagraph (A), the term 'eligible operations and maintenance' does not include providing any lands, easements, rights-of-way or dredged material disposal areas, or performing relocations required for project operations and maintenance.".

6. Sec. 608(4) (unredesignated) is amended to read as follows:

> "(4) The term 'Great Lakes navigation improvement' shall mean any lock, channel, or other connecting waterway improved, operated, or maintained by the United States used principally for the through movement of Great Lakes waterborne commerce and which is located on the Detroit River, Saint Clair River, Lake Saint Clair, Saint Marys River, Straits of Mackinac, or Grays Reef Passage;".

TITLE VIII -- NAVIGATION TAXES

1. Strike the title of Title VIII and insert in lieu thereof the following: "NAVIGATION TAXES AND FEES".

2. Sec. 802 is amended to read as follows:

"SEC. 802. (a) Section 206 of the Inland Waterways Revenue Act of 1978 (33 U.S.C. 1804) is amended to read as follows:

'SEC. 206. INLAND AND INTRACOASTAL WATERWAYS OF THE UNITED STATES.

'For purposes of sections 4042 and 4499 of subtitle D of title 26, United States Code, and for purposes of sections 204 and 205 of this Act, the following inland and intracoastal waterways, including harbors thereon, of the United States are described in this section as follows:

'(1) The Mississippi River and its natural and manmade connected tributaries and waterways upstream from Baton Rouge, Louisiana, including but not limited to, the South Branch of the Chicago River and Cal Sag Channel and Little and Grand Calumet Rivers portions of the Illinois Waterway project, including but not limited to the Allegheny, Arkansas, Cumberland, Green and Barren, Illinois, Kanawha, Kaskaskia, Kentucky, Missouri, Monongahela, Ohio, Ouachita-Black, Red, Tennessee and White Rivers and their tributaries;

'(2) The Gulf Intracoastal Waterway between Saint Marks River, Florida and Brownsville, Texas, and alternate routes thereto, and all natural and manmade waterways inshore thereof with channel depths of fourteen feet or less that are connected directly or indirectly thereto, including but not limited to the Apalachicola, Atchafalaya, Mobile and Pearl Rivers and their tributaries and the Tennessee Tombigbee Waterway, but excluding those channels that are part of a project with authorized channel depths greater than fourteen feet;

'(3) The Atlantic Intracoastal Waterway between Norfolk, Virginia, and Miami, Florida, and alternate routes thereof and thereto, and all natural and manmade waterways inshore thereof with channel depths of fourteen feet or less that are connected directly or indirectly thereto, but excluding those channels that are part of a project with authorized channel depths greater than fourteen feet.

> '(4) The Columbia River and its connected tributaries upstream from a point immediately downstream of the Bonneville Lock and Dam project;
>
> '(5) The Willamette River and its connected tributaries upstream from the portion with authorized channel depths greater than fourteen feet.'.

"(b) The amendments made by this section shall be effective on October 1, 1986.".

3. Sec. 811(a)(2) is amended to read as follows:

> "(2) the term "commercial vessel" shall mean a vessel engaged in waterborne commerce: Provided, That this term shall not be construed to include any vessel excluded from fees within the terms of sections 606(b)(1) through 606(b)(4), or any vessel engaged primarily in the ferrying of passengers or vehicles between points within the United States, or pleasure vessels except such vessels that are transporting bonded cargo.".

4. Sec. 811(a)(3) is amended to read as follows:

> "(3) the term 'person' shall mean a natural person, partnership, corporation, or other entity engaged in commercial activity.".

5. Sec. 811(a)(5) is amended by striking the first sentence and inserting in lieu thereof the following:

> "the term 'value' shall mean the actual transactional value of any commercial cargo as evidenced by such documentation as the Secretary of the Treasury may prescribe by regulations, or the value of the cargo as determined by the Secretary of the Treasury.".

6. Sec. 812(a)(1) is amended by adding at the end thereof the following new sentence:

> "There are hereby authorized to be appropriated to the Trust Fund such amounts as are provided in section 812(b).".

7. Sec. 812(a)(3) is amended to read as follows:

> (3) The Secretary of the Treasury shall be the trustee of the Trust Fund and after consultation with the Secretary, shall report to the Congress not later than March 1, 1988, and not later than March 1 of each year thereafter, on the operation and status of the Trust Fund during the preceding fiscal year and on the expected operation and status of the Trust Fund during the three fiscal years immediately following such fiscal year.

8. Sec. 812(b)(2) is amended to read as follows:

"(2) (A) Subject to paragraph (2)(B), the Secretary of the Treasury shall transfer, not less than at the end of each fiscal quarter, from the general fund of the Treasury of the United States to the Trust Fund an amount equal to the amount of receipts into such general fund during the preceding fiscal quarter from the fees imposed by sections 813, 814, and 815 of this part.

"(B) The amounts transferred to the Trust Fund pursuant to paragraph (2)(A) shall be made on the basis of estimates made by the Secretary of the Treasury of the amounts received for each fiscal quarter. Proper adjustment shall be made in the amounts subsequently transferred to the extent prior estimates were in excess or less than the amounts required to be transferred.".

9. Sec. 813 is amended to read as follows:

"SEC. 813. (a) There is hereby imposed a fee on the use of any commercial channel or harbor or commercial inland harbor within the United States (including such channels or harbors located within the Great Lakes) by a commercial vessel.

"(b) The amount of the fee imposed by subsection (a) shall be equal to 0.04 per centum of the value of the commercial cargo loaded onto or unloaded from such vessel at any such channel or harbor and such fee shall be imposed --

"(1) on the importer or principal on a bond required by the Secretary of the Treasury pursuant to section 817 in the case of cargo arriving from a point outside the United States;

"(2) on the exporter or principal on a bond required by the Secretary of the Treasury pursuant to section 817 in the case of cargo loaded for export from the United States; and

"(3) on the vessel owner in the case of commercial cargo loaded or unloaded in coastwise or domestic trade.

"(c) The fee imposed by subsection (a) shall not apply --

"(1) with respect to cargo unloaded from such vessel that was loaded upon such vessel at the same commercial channel or harbor.

"(2) to commercial cargo transported or to be transported through the Saint Lawrence Seaway.

"(3) with respect to commercial cargo loaded on or unloaded from a commercial vessel subject to the inland waterway fuel tax.

"(d) In the event that a commercial vessel uses more than one channel or harbor on the same voyage, the fee imposed by subsection (a) shall be imposed only once with respect to any particular shipment of cargo.

"(e) The fee imposed under this section shall be effective on October 1, 1986.".

10. Sec. 814 is amended to read as follows:

"SEC. 814. (a) There is hereby imposed a fee on the use of Great Lakes navigation improvements operated or maintained by the United States by a commercial vessel.

"(b) The amount of the fee imposed by subsection (a) shall be equal to 0.04 per centum of the value of the cargo contained in such vessel, as determined by the Secretary of the Treasury in consultation with the Secretary of the Army, at the time of any such use of a Great Lakes navigation improvement and such fee shall be imposed on the owner of the commercial vessel.

"(c) In the event that a commercial vessel uses more than one Great Lakes navigation improvement operated or maintained by the United States on the same voyage, the fee imposed by subsection (a) shall be imposed only once with respect to any particular shipment of cargo.

"(d) The fee imposed by subsection (a) shall not apply to commercial cargo transported or to be transported through the Saint Lawrence Seaway.

"(e) With respect to the same voyage, no fee shall be imposed under subsection (a) to the extent that a fee is payable pursuant to section 813.

"(f) The fee imposed under this section shall be effective on October 1, 1986.".

11. Sec. 815 is amended to read as follows:

"SEC. 815. (a) There is hereby imposed a fee on the use of any commercial channel or harbor within the United States, or a Great Lakes navigation improvement, by a commercial vessel other than a pleasure vessel, without commercial cargo or for a purpose or purposes other than the loading, unloading or transporting commercial cargo, including, but not limited to, convenience, bunkering, refitting, or repair.

"(b) The amount of the fee imposed by subsection (a) shall be equal to $0.005 per net registered ton of a commercial vessel and shall be imposed on the vessel owner.

"(c) The fee imposed by subsection (a) shall not be imposed upon any vessel more than three times in any fiscal year.

"(d) The fee imposed under this section shall be effective on October 1, 1986.".

12. Sec. 816 is amended to read as follows:

"SEC. 816. (a) (1) Any person upon whom a fee is imposed pursuant to section 813(b) shall declare the value of the cargo by which such fee is assessed and shall make payment of such fees in accordance with regulations promulgated by the Secretary of the Treasury.

"(2) Any person who provides commercial cargo for loading onto a commercial vessel by a person upon a whom a fee is imposed pursuant to section 813(b)(3), shall declare the value of such cargo in accordance with regulations promulgated by the Secretary of the Treasury.

"(b) The owner of a commercial vessel shall, in accordance with regulations promulgated by the Secretary of the Treasury --

"(1) in the case of a fee imposed pursuant to section 814, declare the nature and value of the cargo contained on such vessel and make payment of such fee.

"(2) in the case of a fee imposed pursuant to section 815, declare the net registered tonnage of such vessel and make payment of such fee.

"(c) In promulgating regulations authorized under this section, the Secretary of the Treasury may require declarations of value or tonnage to be made under oath and that such values or tonnage so declared are true to the best knowledge and belief of the person making such declaration.".

13. Sec. 817 is amended to read as follows:

"SEC. 817. (a) The Secretary of the Treasury is authorized to promulgate regulations --

"(1) to establish procedures for the collection of fees imposed under this title.

"(2) to designate and require other persons to receive fees from persons upon whom they are imposed pursuant to this title and to remit such fees as the Secretary of the Treasury may direct.

"(3) to require any person upon whom a fee is imposed pursuant to this title or any person designated to receive and remit fees pursuant to this section to file a bond under such terms and conditions as the Secretary of the Treasury deems appropriate to assure the collection of fees imposed pursuant to this title.

"(4) to establish procedures for the collection of all fees under this title with regard to merchandise transported in bond, entered into a bonded warehouse, or entered into a foreign-trade zone.

"(b) The Secretary of Treasury, or any officer or employee as the Secretary of the Treasury may designate, is authorized --

"(1) in order to avoid unnecessary administrative expense and inconvenience to the Department of the Treasury, to waive any fee imposed under this title if the cost of assessing and collecting such fee is, in the judgment of the Secretary of the Treasury, disproportionate to the amount of the fee to be collected;

"(2) to the extent necessary or appropriate to the enforcement of this title or regulations promulgated thereto, or to the imposition of any penalty, forfeiture, or liability arising under this title, including regulations promulgated pursuant thereto --

"(i) to make such investigations and obtain such information from, require such reports or the keeping of such records by, make such inspection of the books, records, and other writings, premises, or property of, and take the sworn testimony of, any person; and

"(ii) to administer oaths or affirmations, and by administrative subpoena require any person to appear and testify or to appear and produce books, records, and other writings, or both.

"(3) for the purposes of assessing, collecting or remitting the fees imposed by sections 813, 814, and 815, to enter into cooperative agreements with public or private entities.

"(c) In the case of contumacy by, or refusal of, any person to obey an administrative subpoena issued pursuant to subsection (b), the district court of the United States for any district in which such person is found or resides or transacts business, upon application, and after notice to any such person and opportunity for hearing, shall have jurisdiction to issue an order requiring such person to appear and give testimony or to appear and produce books, records, and other writings, or both, and any failure to obey any such order court may be punished by such court as a contempt thereof.

"(d) For the purposes of enforcing the provisions of this title, an officer of the United States Customs Service, in addition to any other authority conferred by law, is authorized to --

"(1) stop, search, detain and examine any vessel that contains or may contain any cargo subject to the fees imposed by this title; and

"(2) stop, search, detain and examine any cargo, or package or container in which there is or may be any cargo, that is or is about to be loaded or unloaded in violation of this title or regulations promulgated by the Secretary of the Treasury pursuant to this title.

"(e) Until such time as the Secretary of the Treasury promulgates regulations authorized by this title, any person upon whom a fee is imposed pursuant to this title and any person described in section 816(a)(2) shall keep all records relating to transactions under this title.".

14. Sec. 818 is amended to read as follows:

"SEC. 818. (a) It shall be unlawful for any person to make any false or fraudulent written or oral statement, or to make or submit to a government agency any false or fraudulent entry, claim, certificate, application, declaration or other paper--

"(1) which seeks or affects the payment or remittal of fees under this Act or regulations promulgated by the Secretary of the Treasury; or

"(2) which relates to cargo which is to be exported contrary to law.

"(b) It shall be unlawful for any person to aid or abet any other person to violate subsection (a).

"(c) Sections 592(b) and 618 of the Tariff Act of 1930 (19 U.S.C. 1592(b) and 1618), as amended (relating to pre-penalty and penalty procedures and remission and mitigation procedures) shall apply to alleged violations of this section.

"(d)(1) A fraudulent violation of subsection (a) is punishable by a civil penalty in an amount not to exceed --

"(A) the value of the cargo as determined by the Secretary of the Treasury in the case of a violation relating to sections 813 or 814.

"(B) three times the amount of the fee payable in the case of a violation relating to section 815.

"(C) three times the amount of fees remittable in the case a person designated pursuant to section 817(a)(2).

"(2) A grossly negligent violation of subsection (a) is punishable by a civil penalty in an amount not to exceed --

"(A) 40 percent of the of the value of the cargo as determined by the Secretary of the Treasury in the case of a violation relating to sections 813 or 814.

"(B) two times the fee payable in the case of a violation relating to section 815.

"(C) two times the amount of fees remittable in the case a person designated pursuant to section 817(a)(2).

"(3) A negligent violation of subsection (a) is punishable by a civil penalty in an amount not to exceed --

"(A) 20 percent of the of the value of the cargo as determined by the Secretary of the Treasury in the case of a violation relating to sections 813 or 814.

"(B) the amount of the fee payable in the case of a violation relating to section 815.

"(C) the amount of fees remittable in the case a person designated pursuant to section 817(a)(2).

"(e) In case of failure --

"(1) to make any filing required by the Secretary of the Treasury in connection with the fees imposed by sections 813 or 814 by the date prescribed therefor, unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be added to the fee required to be paid with respect to such filing a civil penalty not to exceed the value of the cargo as determined by the Secretary of the Treasury if the failure is not for more than 1 month, with an additional 5 percent of such civil penalty for each additional month or fraction thereof during which such failure continues, not exceeding 25 percent in the aggregate.

"(2) to make any filing required by the Secretary of the Treasury in connection with the fees imposed by section 815 by the date prescribed therefor, unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be added to the fee required to be paid with respect to such filing a civil penalty not to exceed three times the fee if the failure is not for more than 1 month, with an additional 5 percent of such civil penalty for each additional month or fraction thereof during which such failure continues, not exceeding 25 percent in the aggregate.

"(3) to pay or remit any fee imposed pursuant to sections 813, 814, or 815 as shown on any filing therefor by the date prescribed therefor, unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be added to the fee required to be paid with respect to such filing a civil penalty not to exceed two times the fee if the failure is not for more than 1 month, with an additional 5 percent of such civil penalty for each additional month or fraction thereof during which such failure continues, not exceeding 25 percent in the aggregate.

"(f) If any amount of any fee imposed by sections 813, 814, or 815, or any penalty imposed by this section, is not paid or remitted on or before the date prescribed for payment, interest on such amount, at an annual rate established by the Secretary of the Treasury pursuant to subsections (a), (b) and (c) of section 6621 of title 26, United States Code, shall be paid from the date prescribed for payment to the date such fee is paid.".

15. Sec. 819 is amended to read as follows:

"SEC. 819. (a) Section 1581 of title 28, United States Code (relating to the jurisdiction of the Court of International Trade) is amended by redesignating subsection (j) as subsection (k) and inserting a new subsection (j) as follows:

"(j) The Court of International Trade shall have exclusive jurisdiction of any civil action commenced under Title VIII (excluding section 801) of the Water Resources Development Act of 1985.";

"(b) Section 1582 of title 28, United States Code (relating to the jurisdiction of the Court of International Trade), is amended by designating the current provision as subsection (a) and adding a new subsection (b) as follows:

'(b) The Court of International Trade shall have exclusive jurisdiction of any civil action which arises out of an export transaction and which is commenced by the United States --

'(1) to recover a civil penalty under section 818 of the Water Resources Development Act of 1985;

'(2) to recover upon a bond filed pursuant to section 817 of the Water Resources Development Act of 1985; or

'(3) to recover fees imposed under Title VIII of the Water Resources Development Act of 1985.'.

"(c) Section 1583 of title 28, United States Code (relating to the jurisdiction of the Court of International Trade) is amended --

"(1) by striking the word "or" at the end of clause (1); and

"(2) by striking the period at the end of clause (2) and inserting in lieu thereof the following: ', or (3) such claim or action involves matters covered by section 1582(b).'.".

The CHAIRMAN. Let me ask you a logical question. Customs is something you cannot avoid or evade, legally, that is. You have to pay them.

Why should someone passing through Customs have to pay a user fee anymore than a taxpayer should have to pay the IRS for processing of his or her tax return?

Mr. DEANGELUS. Well, Mr. Chairman, I mentioned earlier that Customs' total resources have increased only three-tenths of 1 percent over the past 10 years. Our workload has grown phenomenally.

We have handled this increased workload through many economies and many administrative changes within the operation of the Customs Service. We proposed over the last 4 years, substantial reductions in the manpower of the Customs Service and changes, administrative changes, in the way we do business to effect efficiency.

The Congress has continually rejected these changes, these administrative changes, permitting these reductions in staffing due to the interest of—which will be presented here today as well as in other committees of this Congress—demanding or requesting greater Customs' services, more Customs' staffing, paid for by the taxpayers of the United States.

And we believe that roughly only 10 percent of the U.S. citizens utilize Customs and Customs' services. They are the ones who are demanding faster, ever faster clearance, faster passenger clearance, faster cargo clearance. They are demanding on the west coast more Customs' staffing.

We believe that since only 10 percent benefit from this, not the 237 million population, not the 96 million people who——

The CHAIRMAN. Can I abbreviate your answer, if I understand it? What you are saying is that only 10 percent of U.S. citizens actually process or use the Customs, even though it is a benefit to everybody in the country. But the middlemen are the ones that ought to pay the user fee.

Mr. DEANGELUS. That's correct.

The CHAIRMAN. Whereas with the taxpayers, 90 percent use it and, therefore, for some reason they shouldn't pay a user fee.

Mr. DEANGELUS. Well, everybody pays the taxes to finance the operation of the Customs Service. Only 10 percent of us citizens utilize the Customs Service.

The CHAIRMAN. I'm curious. In the past—and I can't remember if this administration has taken the position, but other administration agencies have, including the State Department and the U.S. Special Trade Representative—the argument has been that Customs' user fees violated GATT and other international obligations. How does Customs justify its current stance in light of the opposite past positions?

Mr. DEANGELUS. The General Agreement on Tariffs and Trade provides that fees may be charged, but they may not exceed the cost of the services provided. We believe that we have arrived at a process in our proposal which would set fees within the cost of the services provided, and, therefore, there is no problem with the General Agreement——

The CHAIRMAN. But you already collect more money than the cost of the Customs Service.

Mr. DEANGELUS. Those are Customs' revenue, Customs' duty, Senator, and they are separate and apart, we believe, from the GATT provisions for the fees.

The CHAIRMAN. In other words, you are saying those are just tariffs or other forms of moneys and those are general revenues, not user fees, and that is GATT legal.

Mr. DEANGELUS. That's correct, Mr. Chairman.

The CHAIRMAN. Senator Mitchell.

Senator MITCHELL. Thank you, Mr. Chairman.

Mr. DeAngelus, I have opposed the application of the ad valorem tax to cargo entering non-Federal ports in the Committee on Environment and Public Works. I stated my intention to offer an amendment to exempt such ports from the coverage of that tax.

Am I correct in understanding that the administration now supports such an amendment, and, indeed, it is included in the package which you refer to as "technical amendments" that are attached to your statement?

Mr. DEANGELUS. Mr. Mitchell, I believe that is true for those non-Federal ports which were not established through Federal funding. And I think we do generally agree with that amendment, yes.

Senator MITCHELL. OK.

Now I want to get to that point that you referred to in your answer. That is, ports which were established as Federal ports, but are no longer operated or maintained as such. And I would like to use as an example the Port of Eastport, ME, a small town near the Canadian border.

That community has been plagued by high unemployment for many years. And they are now reversing it by expanding their port traffic and revitalizing their economy.

That required port improvements, which the Army Corps of Engineers determined were not justifiable and therefore refused to make them. So to enable them to make the improvements themselves, the local government requested that the port be deauthorized. Legislation to that effect was passed in Congress, and Eastport is no longer a Federal port.

So here's a small town that has been willing with some State support to take responsibility by itself in the maintenance of its port. It seems to me that if the purpose of this legislation is to encourage self-sufficiency and responsibility we should be encouraging ports to deauthorize.

Yet under your amendment, Eastport, having volunteered to pay their own way and in fact paying their own way, would now be called upon to pay for others as well.

And I'll suggest to you that if that occurs, no one will ever deauthorize a port again because there would be no benefit from it.

I would like to ask you this question: How many ports in the country have been constructed with Federal assistance, but since have been deauthorized and are no longer operated or maintained with Federal funds?

Mr. DEANGELUS. Senator Mitchell, I'm a Customs' officer and I suggest, if you would, that the Department of Transportation, Department of the Army, would have that information more readily available than I would. We would be happy to supply it later or when they testify.

Senator **Mitchell**. All right. Would you do that? I am very much anxious to know that because it seems to me that this is a very inequitable situation.

[The information from Mr. DeAngelus follows:]

The Army Corps of Engineers informs us that such information has never been collected. However, based on the collective knowledge of a few of their senior personnel, the Corps advises us that although there have been numerous elements of Federal port projects such as side channels or anchorage areas that were constructed and subsequently deauthorized, they are aware of only one port project (Eastport Harbor, Maine) that was deauthorized in its entirety.

Senator **Mitchell**. I would also like to suggest that you consider this amendment. I would like to have you do so after you get the information.

The amendment that you have listed as No. 3—it's at the top of page 2 of your amendments, on the second line—the last word is "or." It now reads "constructed or operated or maintained." And if you change that first "or" to "and" then you would deal equitably with this situation.

That is, you would limit the tax to those ports that are constructed and currently operated or maintained with Federal funds. So I would appreciate it if you would look at that and respond after you have had a chance to analyze that.

Mr. **DeAngelus**. Thank you, Senator. We will do that.

[The information from Mr. DeAngelus follows:]

Changing the first "or" to an "and" would eliminate a number of Federal commercial navigation projects that were constructed by non-Federal interests and were subsequently authorized for Federal operation and maintenance. A case in point is the proposed Tampa Harbor, East Bay Channel, Florida, project included in Section 609 of the bill.

Senator **Mitchell**. A number of naturally deep Federal ports which require and have received little or no Federal maintenance funds would be required to pay the tax on cargo. For example, in Maine there are three ports which, although Federal ports, have never received a penny in Federal funds of any kind. Another three have received no Federal funds for operation or maintenance for the last 8 years.

I have two more questions I would like to ask you, and you obviously will have to get the answers later.

First, what is the number of federally authorized ports which have never received any Federal funds for operation and maintenance? And, second, what is the number of such ports which have not received any such funds since January 1, 1976?

Mr. **DeAngelus**. We will be happy to get that information.

Senator **Mitchell**. All right.

[The information from Mr. DeAngelus follows:]

Based on the Army Corps of Engineers' Data Management System, there are 33 existing Federally authorized ports deeper than 14 feet that have not received any Federal funds for operation and maintenance since Fiscal Year 1976 (the earliest year the Corps has yearly O&M statistics). Of the 33 ports, three ports have never received any funds for operation and maintenance. A table listing these ports together with the commercial tonnage handled at each port is attached for your reference.

LIST OF FEDERAL NAVIGATION PROJECTS DEEPER THAN 14 FEET WITH NO O&M EXPENDITURES SINCE FISCAL YEAR 1977

[Tonnage and dollars in thousands]

Project	1981 tonnage	Total O&M prior to fiscal year 1977
Metlakatla Harbor, AK	77.1	$50.5
Thames River, CT	425.5	1,422.6
Wilson Point, CT	0	0
Beverly, MA	32.2	16.8
Crossrip Shoals NNTK, MA	27.4	54.3
Dorchester Bay, MA	0	301.9
Lynn Harbor, MA	0	23.9
Nantucket Harbor, MA	33.9	104.9
New Bedford & Fairhaven, MA	171.3	709.0
Pollock Rip Shoals, MA	0	846.6
Salem Harbor, MA	1,228.2	350.9
Seekonk River, MA	0	793.2
Vineyard Haven Harbor, MA	74.8	8.7
Weymouth Back River, MA	0	7.2
Belfast Harbor, ME	30.5	224.4
Cape Porpoise Harbor, ME	0	347.9
Deer Island Throughfare, ME	0	0
Rockland Harbor, ME	4.0	452.8
Searsport Harbor, ME	1,079.0	23.0
Stockton Habor, ME	0	23.2
Tennants Harbor, ME	0.7	13.3
Grays Reef Passage, MI	5,194.5	646.7
Little Bay Denoc-Gladstone, MI	185.4	54.1
Mantua Creek, NJ	0	339.3
Port Jefferson Harbor, NY	3,494.3	359.3
Multnomah Channel, OR	0	6.1
Newport Harbor, RI	16.1	94.8
Providence River and Harbor, RI	6,737.5	3,755.6
Little River Creek, VA	0	442.0
St. Thomas Harbor, VI	312.2	0
Olympia Harbor, WA	259.2	651.6
Port Gamble Harbor, WA	99.4	51.4
Port Orchard Bay, WA	0	12.7
Total	19,480.0	

Senator MITCHELL. Next, I would like to ask you about your definition of commercial vessels. You exempt from the definition of commercial vessels, those vessels engaged primarily in the short-haul ferrying of passengers or vehicles between points within the United States.

In Maine, which of course—which has a border with Canada, we have ferry services which ferry passengers to points in Canada. Is there any rationale for not also exempting ferry boats which transfer passengers between points in the United States and contiguous foreign countries?

Mr. DEANGELUS. Senator, I'm not familiar with the rationale for that. I would have to respond to that later.

Senator MITCHELL. Would you do that?

Mr. DEANGELUS. Yes.

[The information from Mr. DeAngelus follows:]

The exemption of vessels engaged primarily in the short-haul ferrying of passengers or vehicles between points within the United States from the harbor maintenance fees was included in the bill as reported by the Committee on Environment and Public Works. The only change proposed by the Administration is to delete the term "short-haul" for purposes of clarity.

Mr. DeAngelus. But we do also have ferries in the State of Washington to Canada and between Puerto Rico and the Dominican Republic.

Senator Mitchell. That's right. So I would like to get the rationale for that.

Could I ask one more question?

The Chairman. Yes.

Senator Mitchell. Earlier this year, the Customs Service informed Congress that it was considering legislation to place some Customs' ports on a reimbursable basis. You recall that, I'm sure, Mr. DeAngelus.

Mr. DeAngelus. Yes, Senator, very much.

Senator Mitchell. As I understand this, it would have meant that certain low-volume Customs' stations would be required to finance their own operation by obtaining reimbursements from State and local governments or from private commercial groups.

Now if Congress adopts your proposals for Customs' user fees, it would follow logically in my mind that you would then drop consideration of placing some Customs' stations on a reimbursable basis. Am I correct in that assumption? And, if not, why not?

Mr. DeAngelus. You are correct that it is logical in your mind, Senator, but we have not dropped that. It still is under consideration within the administration. And the rationale is this—a different rationale from yours: That these ports that we talk of, these low-volume ports, are what we term convenience ports, that for a number of reasons, people believe that there is a certain status to having a Customs' port of entry, to having a foreign trade zone.

At the borders, the land borders, Mexico, and Canada, many of these ports were established many, many years ago before the automobile was developed, before super highways were developed. And, consequently, it would have been unreasonable to require so much to travel 40 miles to enter or leave the United States.

We believe that today—for example, Noyes, MN and Pembina, ND are 1¼ miles apart—that is wasteful of the taxpayers' money, yours and mine, to maintain two border crossings at that place where people could cross within 1¼ miles.

However, people don't believe that. The local community doesn't believe it. The business interests don't believe it. They believe, they perceive, there are economic benefits to having that border crossing, to having that port of entry.

Consequently, we believe it's unfair to charge all the users, Customs' users, for what we term convenience ports. And, therefore, we are proposing that below this certain minimum that where it would pay for the full salary of a Customs' officer full time, that that legislation should also be included so that the burden of the user fee would not be increased solely for convenience purposes.

And, in fact, Senator Humphrey got a bill passed which became law last year which divides up to five airports of entry to—with the concurrence of the Governor of the State, pay Customs and establish themselves, reimburse Customs' established ports of entry.

And, Senator, three of those have already been allocated. And there are 11 cities lining up for the other 2 slots. They are willing to pay us to establish themselves with ports of entry.

Senator MITCHELL. I'm over my time so I will be brief. You have cited an example of 1¼ miles, but in Maine the effect would be to force people to drive as much as 143 miles in one case. I don't dispute the 1¼ mile, but you must agree that driving 143 miles is the other extreme.

Mr. DEANGELUS. I would agree with that, Senator.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. DeAngelus, are the fees to be collected here to be dedicated to any certain use or do they go to the general revenue?

Mr. DEANGELUS. Senator, they would go to the general fund. However, we proposed the legislation in such a way that they are tied to the level of resources provided.

The CHAIRMAN. You mean the Customs' fees or the port and user fees?

Senator BAUCUS. Talking about the Customs' fees.

Mr. DEANGELUS. We proposed the legislation in such a way that even though they would go to the general fund, they are tied to the level of resources appropriated. In addition, they have to be based on the General Agreement on Tariffs and Trade. I'm not an attorney, but they would have to be based on our interpretation of the General Agreement of Tariffs and Trade that the cost cannot exceed the costs of services provided.

So we think that they are sufficient rationale, even though they are covered under the general fund through the appropriation process, to allow the public and the Congress to pass on the level of services provided.

Senator BAUCUS. I understand what you mean. You say that it goes to the general fund, but it is somehow tied to the resources that are utilized.

I mean are the fees intended to cover entirely the resources that are used in order to administer?

Mr. DEANGELUS. Yes, Senator. They are intended to cover the entire cost of Customs' operation, exclusive of the enforcement operations. Approximately $550 million of Custom's operations out of approximately $800 million.

Senator BAUCUS. Collect about $515 million Customs' fees, then; is that correct?

Mr. DEANGELUS. Correct, Senator.

Senator BAUCUS. How much does Customs Service collect today? Did you say $14 billion?

Mr. DEANGELUS. $14 billion, Senator.

Senator BAUCUS. Isn't that above $550 billion?

Mr. DEANGELUS. It certainly is, Senator. But as I mentioned earlier, we would like to reduce the size of the Customs Service and operate differently.

Senator BAUCUS. I'm sorry. You would like to do what?

Mr. DEANGELUS. Reduce the number of people in the Customs Service and operate differently by doing things like eliminating convenience ports, by reducing the number of regions, which are strictly administrative; by consolidating districts.

Senator BAUCUS. I thought the principle of this was to cover costs, and yet you—on one hand we have established that you collect much more than your costs that are incurred and you are now saying you want to reduce costs, you want to cut your employees.

Mr. DEANGELUS. Senator, I'm saying that many interests in the international trade community are demanding a level of service and a type of service which we don't believe is required under the law. We recognize that $14 billion in Customs' duties, which are a trade mechanism, are collected.

But we believe that the services demanded by the public are not required by the law and that if they are to be provided, especially given the deficit situation which we are here addressing today, that they should be provided with a mechanism of user fees so that those who benefit can pay and receive a requisite level of service.

Senator BAUCUS. What's the average cost of Customs to process a passenger?

Mr. DEANGELUS. Senator, an air passenger?

Senator BAUCUS. Air, sea, port.

Mr. DeAngelus, Well, we have broken them down differently because we devote a different level of resources. And I guess I could—if I may respond to you that a foreign air passenger, including the overtime, it's approximately $2 per passenger.

Senator BAUCUS. $2 for air. What about sea?

Mr. DEANGELUS. $2 for air.

Excuse me one moment, please. I must check my schedule. For sea, it's $2.50.

Senator BAUCUS. What about by land?

Mr. DEANGELUS. By land, it would be approximately $1 per vehicle rather than per passenger because passengers come in vehicles.

And in order not to establish a bureaucracy to collect the fees, we believe that doing it through a mechanism of the vehicle crossing that it would be approximately $1 per vehicle.

Senator BAUCUS. Now are you going to assess different fees according to whether it's by air, land, or sea?

Mr. DEANGELUS. Correct. Based on the number of resources devoted to that type processing.

Senator BAUCUS. Now would there be a difference in fees among various ports? That is, the various seaports. Second, among the various airports. Among the various land crossing ports.

Mr. DEANGELUS. I can understand that rationale, Senator. But, again, what we believe is that not to establish a bureaucracy to collect the fees—we can collect these fees as we have proposed at almost zero costs so that we don't increase the cost of Customs to the user to whom we charge the fee.

That's why the Customs Service has proposed to collect the user fees for the Corps of Engineers in the S. 1567. We have a mechanism in place to collect duties on imports.

Senator BAUCUS. What other countries assess a per capita customs fee?

Mr. DEANGELUS. There are approximately 42 countries of which we are aware that have different, various types of user fees. One is France, I believe, which has a 2 percent on the duty collected. Nicaragua. There are other countries. But the main one, I think, is France. But there are 42 of which we are aware.

Senator BAUCUS. So you are talking about the people—does this apply to people entering the United States or leaving or both?

Mr. DEANGELUS. Our fee would be only for entering the United States. Two dollars for air passengers.

Senator BAUCUS. Does France assess a $2 fee?

Mr. DEANGELUS. Not to my knowledge, Senator. Not to my knowledge does any country have as comprehensive a fee as we are proposing.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, I don't have a great deal to say except that I hope this committee has a chance to talk about this issue.

This is a tax, Mr. DeAngelus. Tariffs are taxes and this is a tariff.

I once knew a distinguished Governor of New York who pledged that he would never raise taxes again in his career. The day after he was elected, he raised taxes, claiming he wasn't raising taxes, he was raising fees. But a tariff is a tax, and this is a tax.

Do you really want to do this? Or were you told you had to find $500 million?

Mr. DEANGELUS. Senator, I accept your assertion that it's a tax. I personally do not believe it is a tax. I believe that others will follow me today. If you will read the record before the Ways and Means Committee, before the Senate and House Appropriations Committees, that various international trade interests will represent themselves before the committee and urge increases in Customs' staffing, increasing in Customs' service, faster service.

We believe that those interests, since they are relatively narrow compared to the interest of the United States and the population of the United States, that those interests should be served, but that they should be served through a mechanism which keeps the services demanded at a reasonable level rather than an unreasonable level.

And if, in fact, they are convenience level, that they should be reimbursed so that the burden will not have to be spread against all taxpayers.

Senator MOYNIHAN. I just want to ask one question. Are the fees to remain exclusively within the Customs Service?

Mr. DEANGELUS. Senator, they would not be reimbursable generally to the appropriation as some of our current user fees are. However, they would be tied to the level of appropriations through the public notice system each year and as well as through the appropriation process and the authorization process, in fact, before the subcommittee. It would be addressed.

Senator MOYNIHAN. Someone just whispered to me that the answer is no.

Mr. DEANGELUS. I think it's——

Senator MOYNIHAN. Is it going into the Treasury's general fund?

Mr. DEANGELUS. Senator, they would be covered into the Treasury general fund.

Senator MOYNIHAN. But is it going to flow through to the Customs Service.

Mr. DeAngelus. But they would be tied to the level of appropriations requested. The fees would have to be set commensurate with the services provided under the GATT and under the legislation.

Senator Moynihan. None of this money is for general revenues?

Mr. DeAngelus. No, Senator. It is general revenue. However, it would be tied to the appropriations.

Senator Moynihan. How do you mean tied, sir?

Mr. DeAngelus. That if we collect $500 million for Customs' services in the commercial area, we would provide $500 million worth of services through the appropriation process so that this committee and others would have a chance with their oversight to determine that Customs was acting in a prudent way.

Senator Moynihan. I think I will have to learn more about this, but I thank you for your response.

The Chairman. You are separating in your mind, as I understand your answer, the roughly $15 billion you collect which is revenue, and that goes into the general fund. You are also saying your user fees are going to go into the general fund. They are not going to go into a trust fund, but the user fee part of what you collect is going to equal the cost of your administration.

Mr. DeAngelus. That's correct, Senator.

The Chairman. Senator Symms.

Senator Symms. Thank you very much, Mr. Chairman.

I guess my question is: What does this do to ticket prices in airlines? And not only ticket prices, but some airlines are international carriers that come in and use—would be carrying passengers that use customers. A domestic flight would not use Customs' services. So, could you give me—have you done any studies on how that will affect the air passenger that doesn't use the Customs' services?

Mr. DeAngelus. Any air passenger not using the Customs Service would not be charged. They would only be arriving passengers from foreign—processing through the U.S. Customs, Senator.

Senator Symms. Any air passenger that——

Mr. DeAngelus. Arriving from foreign, from a foreign country, and processed through Customs. So, that—for instance, there's a flight that comes from London, stops at Seattle, drops off some passengers, picks up some Seattle passengers and then moves on to Los Angeles, and drops off additional London passengers as well as the domestic passengers. The domestic passengers—I'm sorry. I'm incorrect.

In that instance, they would be included in the user processing fee because they must go through Customs again because they are not sterile.

Senator Symms. I'm sorry I missed part of your testimony, but are you envisioning that the user fee is paid by the airline passenger or by the airline?

Mr. DeAngelus. It would be added to the price of the ticket, Senator.

Senator Symms. How much for a ticket?

Mr. DeAngelus. Well, the lowest ticket of which I am aware, one way—now nobody travels one way; they all travel round trip.

But one way is $45 between Miami and the Bahamas. So, if someone is going to pay $90 to travel roundtrip between Miami and the Bahamas, I'm certain he is not going to balk that it becomes

$92 because he's clearing Customs. And he wants to clear it quickly, because he wants to get to the gaming tables or get home from the gaming tables. I estimate that the lowest airfare, which is $90, would not deter one passenger from making the trip because now it would be $92.

Senator SYMMS. What about if they go to Taipei?

Mr. DEANGELUS. If they go to Taipei, 0it would still be $2, because the cost of processing them is relatively the same.

Senator SYMMS. Well, is there going to be any mechanism? If Customs is able to say, "Well, this is not costing the taxpayers any money; we have plenty of money," what is going to be the mechanism that will help Customs from becoming just a giant, giant bureaucracy? I mean, if this was privatized and we were contracting this out, you would have the bottom line. Is it possible to privatize it and contract it out?

Mr. DEANGELUS. I suppose it could, but we don't believe that anybody could do it any more cheaply than Customs. But the mechanism to ensure that is just what we were addressing. Why isn't it made reimbursable to the Customs appropriation, and then there is no oversight process? Well, that is the very reason: The public, through the public notice of the establishment of the fees, and the Congress through the oversight committees as well as the appropriations committees, would see that the fees established and the level of aprropriations each year are reasonable, that Customs is still operating efficiently, is managing well, and is not a bloated bureaucracy.

Senator SYMMS. Is there any ongoing studies to examine, maybe taking one port of entry and contracting it out to a private contractor, and then having a Customs official just inspect and see if they are doing the job, to see if it could be done more efficiently, and not have to hire more people, to put them on the Government Pension Program, and so forth?

Mr. DEANGELUS. No, Senator. There are no studies that way.

Senator SYMMS. Would you welcome such a direction, to try it on an experimental basis in one port of entry? A privatization of the Customs responsibilites?

Mr. DEANGELUS. Philosophically, I am not opposed to such a proposal, Senator. However, as a 26-year Customs officer, I just know that it would not be less expensive to operate that way.

Senator MOYNIHAN. Would my friend from Idaho permit me to address a question to him?

Senator SYMMS. Certainly. I yield.

Senator MOYNIHAN. Did I hear the Deputy Commissioner of Customs say that he was not philosophically opposed to turning the Customs over to private industry? I ask because I represent New York City, and I believe there are a number of organizations that would be very happy to take over the Customs for you, sir, and do it very cheaply. [Laughter.]

Mr. DEANGELUS. Senator, I believe that many would. But I also——

Senator MOYNIHAN. You think you could pick and choose between them, right? [Laughter.]

Mr. DEANGELUS. I also deeply believe that no one could do it more cheaply than we do it.

Senator Moynihan. I know people who would pay for the privilege. [Laughter.]

Mr. DeAngelus. I would have to agree with you, Senator.

The Chairman. Any more questions of the Deputy Commissioner?

[No response.]

The Chairman. If not, sir; thank you for joining us this morning.

Mr. DeAngelus. Thank you, Mr. Chairman.

The Chairman. Next we will have a panel consisting of Daniel McAuley, Ellis Magee, Robert Scott, the Honorable Bob Bolen, and Sam Diannitto.

At the request of Senator Moynihan, I wonder if we might start with Mr. McAuley first, and then we will take the panel in the order that they appear on the witness list.

Mr. McAuley, are you ready?

Mr. McAuley. Yes, I am, Mr. Chairman.

The Chairman. Go right ahead.

STATEMENT OF DANIEL McAULEY, DIRECTOR, NEW YORK STATE SOCIAL SECURITY AGENCY, ALBANY, NY; ON BEHALF OF THE NATIONAL CONFERENCE OF STATE SOCIAL SECURITY ADMINISTRATORS

Mr. McAuley. My name is Daniel McAuley. I am the director of the New York State Social Security Agency located in Albany, and the immediate past president of the National Conference of State Social Security Administrators. Our conference represents the State Social Security agencies from the 52 States and territories, and the 67,000 political subdivisions that make up the Social Security agreement.

The purpose of my testimony is to explain our conference's position regarding the proposal that would take the collection responsibility of Social Security contributions from the State Social Security agencies and place such responsibility with the Internal Revenue Service.

Under this proposal, various increases to the trust funds have been shown, ranging from $700 million in 3 years to $2.4 billion in 5 years.

The Chairman. Mr. McAuley, I might admonish you not to read your entire statement, or you won't finish it in the 5-minute rule we have. All of the statements will be in the record.

Mr. McAuley. Thank you, Mr. Chairman.

This increase is basically obtained in three ways: Increasing the interest charge for delinquent deposits, which is a change that we have recommended for years. This would produce about $18 million over 5 years. The true collection increase in the proposal over a 5-year period would amount to about $300 million. In all other projections, the monetary increases shown are artificial one-time increases obtained by changing the period under valuation. Moneys that are already accounted for are backed into a different valuation period; showing a one-time artifical increase.

Our conference has recommended four measures which will give a true monetary increase to the trust funds over and above the actual increases in the acceleration without changing us as the collection agent or disrupting the integrity of the State Social Security agencies. These are contained in my written testimony.

I would like to examine some of the facts. The claim by Internal Revenue Service is they can take over our responsibilities with no increase in manpower. We presently have staffs of 325 full-time employees, with peripheral support from 200 employees representing field auditors, programmers, counsels, and our attorney general's offices.

I think it was very interesting to note the speaker from Internal Revenue Service this morning made a statement that, if we switch to the Internal Revenue Service deposit schedule we would have a more efficient system. Under our Social Security agreement, each State has agreed to pay 100 percent of the liability for Social Security contributions for every political subdivision they represent. In our 35-year history there has never been one case of default. The trust funds have never lost one penny of contributions or interest in 35 years.

Studies by the U.S. Comptroller General indicate that the collection of income and Social Security tax is the foremost delinquency problem facing the Internal Revenue Service today. I would like to know how they can make a statement they can run a more efficient system when, according to their own studies, they found it is not cost efficient to prosecute all delinquencies.

The majority of the political subdivisions we represent are small entities staffed by part-time people. It has taken us years to establish the relationship and obtain the cooperation of these political subdivisions. If they are delinquent in their payment, they can be assured that they will be contacted by us. They are also assured of our assistance and prompt responses to any calls or correspondence. That type of assurance cannot be made by the Internal Revenue Service.

The term "accelerated deposits" itself is a misnomer. We have studied and found that in the majority of cases the political subdivisions would actually decelerate their payments. Since the majority of the political subdivisions are smaller entities, under the Internal Revenue Service schedule they wouldn't pay twice a month, they would pay either monthly or quarterly. And by this loss of contact and reporting, I am sure that the delinquency rate would also go up.

Thank you, Mr. Chairman.

[Mr. McAuley's written testimony follows:]

TESTIMONY OF
DANIEL J. McAULEY
IMMEDIATE PAST PRESIDENT

THE NATIONAL CONFERENCE OF STATE
SOCIAL SECURITY ADMINISTRATORS

My name is Daniel J. McAuley. I am the Director of the New York State Social Security Agency and Immediate Past President of the National Conference of State Social Security Administrators. The purpose of my testimony is to express our Conference's position and concerns regarding the President's budget proposal on social security which, if adopted, would change the method by which the States and their political subdivisions deposit their social security contributions. The proposal would take the collection of social security contributions from the control of the State Social Security Agencies and place such responsibility with the Internal Revenue Service. I presented similar testimony before the House Ways and Means Committee on June 19th of this year.

Under this proposal, increases to the Social Security Trust Funds ranging from 700 million dollars over the next three years to 2.4 billion dollars over the next five years are projected. The increase is obtained from three sources. One is the change in the rate of interest charged for the late receipt of social security deposits. This would generate approximately 18 million dollars over the next five years. The second is the collection increase obtained from the change in deposit schedule. This would account for approximately 323 million dollars over the next five years. The third is an actuarial method which produces a one time artificial increase by changing the period under valuation. Using this third method, the remainder of the dollar projections is obtained.

I have examined this proposal in an attempt to find a means of arriving at a real billion dollar plus increase to the Trust Funds. I find this cannot be done, since in reality there is no way of increasing revenues to the Social Security Trust Funds by a billion dollars or more from State and Local Government social security deposits. The projections used do not represent a true monetary increase, but consist mainly of an amount obtained by backing in already accounted for social security contributions from one valuation period to another. The real monetary increase of approximately .4 billion contained in this proposal can be obtained by other measures which would neither alter the present method of social security collection nor disrupt the integrity of the State Social Security Agencies.

I will explain this method shortly, but first, let's examine some of the claims and facts. It has been said that the Internal Revenue Service can assume the collection responsibility of State and Local social security deposits without an increase in manpower. At present, State Social Security Agencies employ approximately 325 full time employees with peripheral support from an additional 200 employees representing attorneys, field staff, programmers, auditors, and counsel of the State's Attorney General's office. The past record reveals the Internal Revenue Service has been unable to collect all social security monies due from private sector employers and employees. In a previous report released by the U.S. Comptroller General, it is stated that the collection of income and social security tax is the foremost delinquency problem facing the Internal Revenue Service. The report also states that according to IRS studies, it may not be cost effective to pursue all delinquencies. Further, their past programs to prosecute employers' filing false deposits had to be discontinued because of the difficulty they encountered in proving criminal willfulness.

Similar situations do not exist in the public sector with the political subdivisions we represent. Political subdivisions who remain delinquent after request for payment are litigated by our respective State Attorney General's Office until satisfaction is obtained.

My intent in this presentation is not to discredit the social security collection operation conducted by the IRS in the private sector, but merely to point out that the State Social Security Agencies have already addressed and resolved the problems that continuously plague private sector reporting.

Perhaps the greatest argument in favor of retaining the State Social Security Agencies as the collection agent is that under the States' agreement, there is a 100% guarantee for the payment of all social security contributions due from all States and their political subdivisions. In the thirty-five year history of State and Local Government participation in the social security program, there has never been a case of default of payment. The State Social Security Agencies' record of social security contribution collection and control is unblemished. The political subdivisions we represent have been schooled in the proper method of social security reporting and depositing and of the sure consequences if they fail to comply. They are also assured of timely and accurate information if they have a problem. This kind of assurance is not provided in the private sector. Many of the political subdivisions we represent are small rural communities, staffed by part-time employees who require constant follow-up to achieve compliance. This individual attention we provide them has fostered a feeling of cooperation that has taken years to develop. The loss of the individual services we provide to these political subdivisions would not be replaced under this proposal, and I am sure the effects of this loss would not only promote both discontent and non-compliance, but monetary losses to the trust funds as well.

Although this proposal has been referred to as an accelerated deposit schedule, a high percentage of our political subdivisions would actually deposit their social security contributions less frequently, based on the IRS deposit schedule. This decline in reporting frequency would no doubt also increase their delinquency rate. If IRS has already determined it may not be cost effective to pursue smaller delinquencies, what part of the projected increase in this proposal would be lost?

Since the inception of the Federal/State Social Security Agreement, the Social Security Administration has benefited by the expertise provided by our Conference, as witnessed by the many improvements achieved in the public social security program through the joint efforts of both our organizations. The Federal government has also been well served by the State Social Security Agencies, not only as their collection agent, but as a buffer and interceptor of all the calls, correspondence and headaches that 67,000 political subdivisions can generate. We act as a liaison between State and Federal government. The small as well as the large public employer receives our personalized attention. To consider the abolition of the State Social Security Agencies as the collection agent for social security contributions after a review of these facts, for the satisfaction of a one time paper increase, is incomprehensible.

As previously stated, alternative measures exist to obtain an actual 4 hundred million dollar increase without altering the current collection procedure.

1) Amend Section 218(j) of the Social Security Act by changing the current rate of interest assessment for delinquent deposits. Anticipated increase is 18 million dollars.

2) Require the Social Security Administration to change their procedure regarding their billing of interest charges to the States due to the late deposit of social security contributions. Anticipated increase is 4 million dollars.

3) Require State Social Security Agencies to wire transfer their semi-monthly social security deposits and require the Federal Reserve Banking System to credit these monies to the Social Security Trust Funds within one day of receipt. Anticipated increase is 172 million dollars.

4) Require State Social Security Agencies to annually turn over their short term interest earned on their collection of social security contributions, save for their cost of operation and a 10% management fee. Anticipated increase is 216 million dollars.

These figures were determined by using the same low middle assumption used by the Social Security Administration in their projections. By using this alternative approach an increase in excess of 400 million dollars can be achieved without disrupting one of the best run and fully guaranteed collection operations in both State and Federal government.

Two other proposals are being considered which, if adopted, would affect the operations of the State Social Security Agencies. They are medicare coverage and/or universal social security coverage for non-covered state and local governmental employees. The NCSSSA does not take a position on these issues. However, if either or both of these proposals become law, it is necessary that the language of this legislation place the social security collection responsibility with the State Social Security Agencies. The political subdivisions we represent should only be responsible to one agency for their social security coverage, reporting and depositing requirements. It is imperative that our political subdivisions continue to be served by the best system possible, and the State Agencies past record speaks for itself.

In conclusion, I would recommend that before any decision is rendered on these issues, a task force including State Social Security Administrators be formed. This group would be assigned to review and recommend changes which would truly serve the mutual interests of the political subdivisions, the Social Security Trust Funds and most importantly, our constituents in the public sector.

Thank you.

Senator MOYNIHAN. Mr. Chairman.

The CHAIRMAN. Yes?

Senator MOYNIHAN. Could I just interject one point here? Mr. McAuley did not get to a point in his proposal that I would like to emphasize.

Do I understand correctly sir, that you are proposing that we adopt legislation that would require you to turn over the short-term interest that you earn on the moneys you collect? And that you anticipate that this would produce $216 million per year?

Mr. MCAULEY. That is correct, Senator.

Senator MOYNIHAN. When was the last time anybody came along with an offer of $216 million, Mr. Chairman?

The CHAIRMAN. I think it was just prior to the entry into World War I. [Laughter.]

Senator MOYNIHAN. Well, I would like to set this on the record. I don't claim to possess much knowledge, but I think we have a system here that works. Every penny owed to the system is collected. And Mr. McAuley says in addition, times being tough as they are down here, he is willing to give up interest earnings to the tune of more than $200 million a year?

Mr. MCAULEY. Well, Senator, when we explored the issue we found that over a 3-year period there was about $200 million of actual increase. What we wanted to do as a conference, to show good faith and not argue the issue, was simply to at least match the amount of the true monetary increase, and we found we could do it without disrupting our agencies. That was our proposal.

Senator MOYNIHAN. And there is $172 million that can be picked up by just wiring the money in faster?

Mr. MCAULEY. That is correct.

Senator MOYNIHAN. You are offering us about $400 million a year?

Mr. MCAULEY. That is correct.

Senator MOYNIHAN. Mr. Chairman, accept that man's offer, will you? [Laughter.]

Thank you, Mr. McAuley.

Mr. MCAULEY. Thank you, Senator.

Senator MOYNIHAN. Now, let's see; that's one-two-three-four-five-six-seven—seven times four is $2.8 billion a year. Now on with this panel. [Laughter.]

The CHAIRMAN. We'll give them more time.

Mr. Magee.

STATEMENT OF ELLIS MAGEE, EXECUTIVE ASSISTANT ATTORNEY GENERAL, LOUISIANA DEPARTMENT OF JUSTICE, STATE OF LOUISIANA, BATON ROUGE, LA

Mr. MAGEE. Thank you, Mr. Chairman and members of the committee.

I appear here in opposition to the proposal to require mandatory Medicare coverage of State and local employees and to require Social Security coverage effective January 1, 1986, for new employees.

The first objection is that the impact of this will be disproportionate on mainly the people from about 8 or 10 States. And, unfortunately, Louisiana is one of them. This adverse impact would occur at a time when Louisiana is really not in good shape to handle it. Louisiana at this time has the second-highest unemployment rate in the country. And although we increased taxes last year by $700 million, we are facing declining revenue, we are having layoffs of employees both at the State and local level, and we are having cutbacks in services.

Baton Rouge, the 39th largest city, is in the process of having a cutback of somewhere in the neighborhood of 150 to 250 employees. The State government is experiencing the same kind of difficulty. And this would be an expensive proposition for the State of Louisiana. Immediately there would be an additional cost of $14 million per year for the Medicare coverage, and we would rapidly move toward an increased cost level of about $90 to $100 million per year in order to meet the Social Security tax for the new employees. And this is not the time that Louisiana can afford that kind of added expense. If it is imposed on us, it means we are either going to have to cut back our retirement benefits sharply or we are going to have to try to find the money, and this is the wrong time to try to do that. So, the timing is very, very bad.

We have a special problem in Louisiana. Some of the retirement systems have no unfunded liabilities. Our retirement systems have somewhere in the neighborhood of $4 to $5 billion of unfunded liabilities, and, although 17 percent of payroll goes into the retirement system, 7 cents of that 17 cents is required to take care of the unfunded liability. And that will continue to be an expense, even though the new employees would be under Social Security.

So, we are talking about a very expensive proposition for our State, and we are talking about disrupting something that is working well.

I would point out to the committee that many of these retirement systems at the State and local level were created before Social Security was passed in 1953. And from 1935, until the early 1950's, State and local employees could not participate in Social Security; they were forbidden to. So, Congress, in effect, created a policy that stimulated the development of these retirement systems and should not now come along and in effect destroy them, do something that is disruptive, solely for the purpose of making it appear that we are balancing or coming closer to balancing the budget.

And I point out that even if we double the Social Security tax, that would not really solve our deficit problem. And so, we shouldn't pick on these 4/5 to million public employees and the States and cities for which they work in order to make it appear that we are moving toward some solution to the problem.

And I would add that it is very important to us to have flexibility in designing our benefit packages. We need to do what we can to recruit and keep teachers. And so if we need to set it up so that teachers can retire at the end of 20 years of service in order to accomplish that objective, we need that freedom, and we don't have that kind of flexibility if we have Social Security imposed on us and if we have the additional cost that goes with it.

Finally, I would point out that it will be a legislative and an administrative nightmare for us to try to meet a January 1, 1986, deadline. That is a very impossible thing.

One final point before the yellow light goes out: These systems have $200 billion in assets that can be used for capital formation. And we should not do away with a program that provides that kind of source of capital formation.

We have a brand new program in Louisiana that is called Pelican Mac, and that is $25 million going into single family mortgages. And that sort of thing ought to be encouraged rather than destroyed.

Thank you very much for the chance to appear. I will be glad to answer your questions.

The CHAIRMAN. Thank you, sir.

We will take Mr. Scott. And I see that he is accompanied by Governor Peabody.

Governor, it is good to have you with us.

Governor PEABODY. I am glad to be here, Mr. Chairman.

[Mr. Magee's written testimony follows:]

STATEMENT OF ELLIS C. MAGEE ON BEHALF OF THE STATE OF LOUISIANA

Before The Senate Finance Committee

September 11, 1985

Mr. Chairman and Members of the Senate Finance Committee. My name is Ellis C. Magee. I am employed by the Department of Justice of the State of Louisiana, and my title is Executive Assistant Attorney General. I am appearing here today on behalf of the State of Louisiana in opposition to two proposals:

1. The proposal to make Medicare mandatory for all state and local government employees; and
2. The proposal to require that all new employees hired by state and local governments on and after January 1, 1986 must become a part of the Social Security System.

The State of Louisiana vigorously opposes these proposals for the following reasons:

1. The proposals are not related to the achievement of the objective of deficit reduction.

If the Social Security System were in need of additional revenues, the Congress might be justified in considering the proposals mentioned above. But that system has no such need at this time. There is a very large deficit in the federal government's other operations and the above proposals are offered as a means of making it appear that something is being done to deal with that deficit.

If social security taxes were doubled, the use of the unified budget might make it appear that a substantial deficit reduction had been achieved, but such appearances would be very deceiving because all such social security system revenues go into the trust fund for that system and are unavailable for expenditure for any other purpose.

Congress has recognized the need to remove social security from the unified budget by scheduling that removal to occur in 1992. And President Reagan has recently urged Congress to move up the effective date of that change.

Therefore, it seems that President Reagan was fully justified last month in observing that the attempt to show a reduction in the federal deficit by including the social security system surplus in the computation is a "bookkeeping gimmick."

Any effort to reduce the federal deficit must be based upon an increase in taxes, a reduction in expenditures, or a combination of the two. No increase in the social security system surplus is going to decrease the federal deficit.

2. The proposals would be very costly for state and local government in Louisiana at a time when revenues are declining and unemployment is high.

We estimate that the above proposals would result in increased expenditures by the state government alone of from $90 to $100 million per year. And the timing could hardly be worse.

Louisiana's rate of employment is the second highest in the nation. Government revenues are declining at both the state and local levels. Layoffs of government employees and cutbacks in services have become a way of life in the last three years. And the end is not in sight.

But that's just the beginning of the bad news. In February of this year, in the Garcia case, the U. S. Supreme Court reversed a 1976 decision by that court with the result that the Federal Wages and Hours Law may now be fully applicable to state and local government. As a result, public employees who work overtime must now be paid time and a half instead of operating on a compensatory leave arrangement, according to federal authorities. This change greatly increases personnel costs for state and local governments.

And that's not all the bad news from the federal level. Congress is now considering several proposals that would be budget busters for state and local governments. These proposals include the proposal to limit state tax deductibility under federal income tax laws, the proposal to reduce or eliminate revenue sharing, and the proposal to end the federal tax exemption of bonds issued by state and local governments.

All of this might somehow be managed by state government in Louisiana if it could incur a deficit for a year or two, but the Louisiana Constitution flatly prohibits the state's operating with a deficit for even one fiscal year.

3. The unfunded liabilities of the State's Retirement Systems complicate the State's job of implementing the proposals.

The unfunded liabilities of the State's two largest retirement systems total approximately $4 billion. The consulting actuary for one of these, the Louisiana State Employees Retirement System, made the following statement in his actuarial evaluation of the system as of June 30, 1984:

> "The annual cost of maintaining the system in sound actuarial condition in the absence of any unfunded past service liability is the normal cost, which expressed as a percentage of payroll, is currently 10.270%."

Since the state employee pays 7% of salary to the retirement system, the State of Louisiana as the employer only pays 3.2% of payroll to fund the package of benefits offered to state employees. The remainder of the 10.2% of payroll paid by the state is available to decrease the unfunded past service liability.

If the proposals now under consideration by this Committee are approved by Congress, the State of Louisiana as employer would have to pay 7.05% of payroll to the Social Security Administration for newly hired employees (and this tax is projected to progressively increase in future years). The turnover rate for state employees has been running in excess of 20% per year; therefore, only a few years would elapse before the state would be paying this larger percent of payroll (7.05% vs. 3.2%) on the majority of its employees. Obviously, it will be necessary for the state to continue payments to the retirement systems to deal with the unfunded accrued liability regardless of whether the newly hired employees participate in the public retirement system.

Accordingly, it is clear that the adoption of the proposals under consideration by this Committee would greatly increase the operating costs of state government in Louisiana in the years ahead and that the impact would be progressive.

4. Impact on the State of Louisiana from a personnel recruitment standpoint.

At present, one of the most attractive incentives of state employment is the package of benefits offered to the state employee in the areas of regular retirement benefits, disability benefits and survivor benefits. If the State of Louisiana tries to maintain the present package of benefits for newly hired employees, the employee would be called upon to pay 7% of his gross earnings to the Retirement System and

7.15% as a Social Security tax (a total of 14.15% of his earnings).

Prospective employees are not likely to consider this to be an attractive arrangement, particularly, in view of the fact that state pay scales are generally lower than those in the private sector. Even if the prospective employee is willing to pay 14.15% of his earnings to the Retirement System and to the Social Security System, it is very unlikely that the State of Louisiana would be able to match such payments, as it would be required to do.

The State of Louisiana needs flexibility in designing the employee benefit packages offered to the different categories of public employees. A teacher shortage is developing. Therefore, it is very important that the state's benefit package for teachers be designed to attract and keep teachers in the profession even if that means permitting retirement after 20 years of service.

Similarly, it will be very difficult to attract high quality applicants for the state police if they are told that they cannot retire until age 62 (perhaps 65) regardless of the number of years of service.

State employees have not had a payraise in Louisiana since 1981. The one thing that prevents the turnover rate from becoming totally unacceptable in such a situation is the benefits packages now offered by the various retirement systems. The adoption of the proposals under consideration by this Committee would make it virtually impossible for the

State of Louisiana to continue offering these attractive benefit packages to prospective employees.

5. Mandatory January 1, 1986 effective date of proposals does not permit orderly implementation.

The Regular Session of the Louisiana Legislature ended several weeks ago. During that Regular Session, the Legislature approved the General Appropriations Bill for the Fiscal Year that began July 1, 1985 and runs through June 30, 1986. If the above proposals become law, the heavy fiscal impact alone would require the holding of a Special Session of the Legislature to make further cuts in services and to mandate additional personnel layoffs in order to generate the money required to pay the taxes due the Social Security System.

Consideration would probably be given at such a Special Session to the revamping of the laws governing the various public employee retirement systems in the state. But, inasmuch as revising the federal retirement program has not been completed even though two years have elapsed since Congress decided to include new federal employees in the Social Security System, it would not be reasonable to expect that the Legislature could, on such short notice, complete the job during the Special Session of revising Louisiana's retirement laws.

Accordingly, we would urge that, if the proposals are adopted in spite of the opposition of 5 million state and local government employees, the effective date of the changes be moved to January 1, 1988 (January 1, 1987 at the very least) in order to allow the states time to make adequate preparation for the implementation of such a major change in federal law.

6. Constitutionality.

Many attorneys who specialize in constitutional law believe that the above proposals are unconstitutional and that the U. S. Supreme Court would so hold. Because of the disproportionate impact of the adoption of the above proposals on about 10 of the states, there could be little doubt that major litigation would result from the adoption of these proposals. In order to avoid unnecessary confusion and monumental disruption at all levels of government, the Committee is urged:

(a) to decline to approve the proposals because of their doubtful constitutionality; or

(b) in the alternative, to select an effective date for the proposals that will permit completion of the litigation prior to that effective date.

STATEMENT OF ROBERT J. SCOTT, EXECUTIVE DIRECTOR, PUBLIC EMPLOYEES RETIREMENT ASSOCIATION OF COLORADO, DENVER, CO; ACCOMPANIED BY HON. ENDICOTT PEABODY, FORMER GOVERNOR, STATE OF MASSACHUSETTS

Mr. SCOTT. Mr. Chairman, members of the committee, members of the staff, let me first say that, in addition to being the executive director of the Public Employees Retirement Association, I am also the former State auditor of Colorado and the former State controller.

I would like to say that I am here for the same reason that Mr. Magee is here, also to say that I represent an organization called Oppose, which consists of employee groups in Massachusetts, Ohio, Illinois, Nevada, and Colorado. All of these groups have elected not to join the Social Security system.

I would like to briefly cover about five points:

One is the impact on State and local entities, the second is the impact on the employees, and I think that needs to be thought through carefully, also. The third is the fiscal policy itself. As a former controller and auditor, I think there are some things that you should know about that. Also, there is an effect on the financial markets of bringing these systems into Social Security. And finally, there are some constitutional problems we see.

To begin with, Senator Kerry, I think, covered very well the impact on State and local entities, the costs that we are going to be facing, and the problems and the kinds of hits that we have taken in recent years and that we are faced with in some of the tax proposals.

Let me just add another one. As the result of *Garcia* v. *San Antonio,* we are faced with the wage and hour law. That is going to be another hit.

So, a lot of the things that you are doing here are really beginning to take their effect, and I think this would be another problem for the States.

Also, on the second point as to the employees in Colorado, you are talking about firemen, policemen, teachers, municipal workers, social workers, college professors, and staffs. The average salary of all of the people in our fund is about $22,000 a year. Our retirement system is more efficient than the Social Security system for the very simple reason that most of the dollars that eventually get paid to these people don't come from the employer or the employee; they come from investments over a lifetime of earnings for these people. We are not tapping into the next generation of taxpayers. And I think that is a very, very important thing to understand.

If you bring us into Social Security and you force us to integrate, we are going to be forced to change our systems, and we are going to have to give up some of the decent provisions that we have got, such as very effective cost-of-living formulas, very effective disability formulas, and the kinds of things that we think have done an awful lot to make for quality employment for our employees in the absence of high salaries.

And I think it is very important that you know that, as far as I am concerned, this is a very illusory deficit reduction proposal. You are not reducing your deficit at all; you are trading a short-term increase in cash-flow for a long-term increase in the national debt. The transfer of debt to the next generation of taxpayers as a result of Social Security is becoming staggering. Why do you want to add to that just to make your short-term cash-flow look a little bit better? That is effectively what you would be doing.

I think, also, in this same line, that in 1976, a House committee criticized a proposal by the city of New York at the time, to use pension fund dollars to help bail our their deficit. The House used this proposal as a reason to start to institute regulation of public employee pension funds. I would ask that you perhaps apply the same standard to yourself. You don't need these trust funds to help you with your deficit.

Finally, the next point, as to the effect on financial markets: The 20 largest public employee pension funds, adding on to what Mr. Magee said, invest $73 billion into the economy, into capital formation. Our fund has put $500 million directly into Colorado in mortgages.

A final point. As to the constitutional argument, I guess there are an awful lot of folks advocating universal coverage that think that *Garcia* v. *San Antonio* opened the door. We don't think it did. We think there is still an awful lot of room to argue that this is a tax on the State. It is not a good social program; it is not a good fiscal program; and we think we will probably be back before the Supreme Court on this very issue.

One final comment, I think that—to add on to what Senator Kerry said—as a former State auditor I can tell you that, if you do a little work on your enforcement program, you might find some of the dollars that you think you can get from us.

I had three staff members 2 years ago that picked up about $20 million out of oil and gas leases on Federal lands, and it wasn't that difficult to do. So, I think some work needs to be done there.

Thank you.

The CHAIRMAN. Thank you.

Governor, do you have some comments?

Governor PEABODY. No, thank you, Mr. Chairman. I am just accompanying him.

[Mr. Scott's written testimony follows:]

STATEMENT OF ROBERT J. SCOTT ON BEHALF OF ORGANIZATION FOR THE PRESERVATION OF THE PUBLIC EMPLOYEES' RETIREMENT INDUSTRY AND OPPOSITION TO SOCIAL SECURITY EXPANSION TO SUCH INDUSTRY

(OPPOSE)

Members of the Senate Committee on Finance, I am Robert J. Scott. I am submitting this testimony on behalf of OPPOSE, a Colorado corporation formed by public employee groups in that state, as well as the states of Nevada, Ohio, Illinois, and Massachusetts, who have elected not to join the social security system. OPPOSE was formed to assure the continued financial integrity of its members' retirement plans by opposing congressional efforts to mandate social security coverage of those members. With respect to this issue, the interests of the members of OPPOSE are identical to those of the nearly five million public employees nationwide who remain outside the social security system.

I submit this testimony in vigorous opposition to proposals currently offered in the Congress to impose HI coverage upon all state and local employees, and OASDI coverage upon all "new hires," effective January 1, 1986, in order to meet the S. Con. Res. 32 requirement of raising $8.4 billion over the next three fiscal years

I would point out that the National Commission on Social Security Reform thoroughly studied the issue of mandatory social security coverage for state and local employees in 1983, when it adopted a package to refinance the system -- and chose not to recommend such coverage to the Congress. I have outlined below some of the numerous valid reasons against such coverage, which should not now be brushed aside lightly in the rush to achieve budgetary savings.

1. Mandatory social security coverage would impose an overwhelming cost burden upon state and local governments already besieged by increases. In 1980, under commission from Congress, the Universal Social Security Coverage Study Group published a report which conclusively established that mandatory social security coverage would result in the transfer of significantly higher retirement costs to state and local governments. This report included a study performed under contract by 13 independent actuaries, which analyzed retirement plans of independent state systems of all sizes and illustrated proposed new benefits and costs for those systems, once coordinated with social security.

A key finding of the study was that the overall actuarial costs of the proposed coordinated plans, including social security taxes and assuming approximately equal benefits, would increase on the average by 5% to 8% of payroll. Costs would increase for each of the plans studied; in some cases, the increase would be as high as 12%.[1] We also note that the present combined OASDI tax rate of 14.1% is close to the assumption used to predict the higher cost -- and is scheduled to go higher.

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[1] Report of the Universal Social Security Coverage Study Group at 195, a copy of which is attached as Appendix A (March 1980).

For the state of Colorado, which would experience an increase of between 5.45% and 8.23%, this translates into a cost increase of between $80 million and $160 million per year. If Congress covers only "new hires," we estimate that 50% of Colorado's non-covered positions would be filled within five years by social security-covered workers. Thus Colorado would experience sharply increased costs in a short time. Indeed, the Universal Social Security Coverage Group study estimated that, for Colorado, the increase in total retirement costs over a transition period, if new employees alone were brought into social security, would be 8.92% of payroll.[2]

The Massachusetts Office of Federal State Relations has estimated that imposition of the HI tax upon all its employees at the state level would increase its costs, as well as those for its employees, by $85.5 million over the next three years. It further estimates that the cost of adding new hires to the OASDI system would equal $41.4 million for the state, and an equal amount for those employees over three years. Thus the proposals currently before this Committee would cost the state of Massachusetts approximately $126 million over the next three years.

2/ Report of the Universal Social Security Coverage Study Group at 222, a copy of which is attached as Appendix B. Colorado's plan, the Public Employee Retirement Association, is designated H-5.

Ruling Costly To Localities

Up to $15 Million Expense for District

By Lee Hockstader
Washington Post Staff Writer

A recent Supreme Court ruling forcing state and local governments to adhere to federal wage and hour laws will add $10 million to $15 million a year to the costs of operating the D.C. government and hundreds of thousands of dollars to suburban governments, area officials say.

That is only a small portion of what is now estimated to be the overall $2 billion to $4 billion cost to state and local governments from the ruling that forces the governments to pay overtime wages to most of their workers instead of giving them compensatory time off.

"It's too much money," complained attorney Gilbert J. Ginsburg, a labor lawyer who is an adviser to many cities, including Alexandria and New York.

The ruling "hits very, very hard and is a burden," said Cornelius J. O'Kane, Fairfax County's personnel director. Officials there estimate the court's Feb. 19 ruling will cost Fairfax taxpayers $500,000 to $1 million a year.

Most of the added costs will come in overtime to police and firefighters, who in the past have earned substantial amounts of compensatory time off.

For example, one immediate impact of the ruling is in western states such as California, where thousands of firefighters will be collecting time-and-a-half overtime pay for battling the forest fires that were out of control in that region last week. Paying the California firefighters overtime wages, rather than compensating them with time off later, will cost $10 million to $20 million, according to James D. Mosman, the state's director of personnel administration.

A10 Monday July 15, 1985 APPENDIX D The Washington Post

Supreme Court Ruling Costly to Localities

OVERTIME, From A1

Cities, which are expected to be hit the hardest when the Labor Department starts enforcing the court ruling Oct. 15, are raising the possibility of layoffs, reduced services or higher taxes. Officials in the Labor Department and the White House say they have been flooded with calls and letters from mayors worried about the impact of the ruling on their budgets.

Local governments attacked the ruling when it was announced, but say they are only now beginning to add up the likely costs as their budget and personnel officers supply them with more precise estimates.

"We are just now getting a handle on it, and it is very difficult," said Donald Weinberg, the District's director of labor relations. "It is causing a real problem."

District officials say the impact of the ruling here will not be as severe as in some other large cities because Washington already pays overtime to many of its employees. "If there are no other pressures then it is clearly manageable," said Betsy Reveal, the District's budget director. "But it cannot be seen in isolation. In combination with other pressures it could cause problems." The District's annual payroll is about $850 million.

Under guidelines for the Fair Labor Standards Act, which state and local governments now must follow, police must receive overtime pay if they work more than 171 hours in a 28-day period. For firefighters, overtime must be paid after 212 hours.

Blue-collar employees in public works as well as clerical and technical employees, many of whom commonly work overtime hours, would also be covered. Teachers, as professional employees, are excluded from coverage under the law.

The Supreme Court ruling came in a case known as *Garcia v. San Antonio Metropolitan Transit Authority* on the question of whether overtime provisions in the act apply to municipal workers.

Joseph Garcia, a bus driver in San Antonio, had brought suit against the city, challenging its practice of paying time-and-a-half overtime only when bus drivers worked on their days off or on holidays. For all other overtime hours worked, bus drivers were paid at the normal hourly rate. The city said it should be exempt from the act; Garcia, backed by labor unions, said it should not.

The 5-to-4 high court ruling has diverse implications. For example:

■ Municipalities will no longer be able to accept volunteer or subminimum wage services from their employees. Crossing guards—frequently senior citizens working for little or no pay—will have to paid at least a minimum wage, for instance. This provision is expected to hurt small towns, which frequently depend on volunteer workers to a large degree.

■ Municipalities may have to pay substantial sums of overtime wages to police recruits in academies who devote long hours to their training. "We've heard of an instance where trainees are paid at a higher rate than police captains," said a White House official. The official, who asked not to be identified, said the likely effect in that instance would be a cutback in training time for police officers.

■ Public employees in some rural jurisdictions who saved compensatory time by working long hours in the winter so they could plant their crops in the spring will be unable to continue that practice.

■ In Puerto Rico, implementing the act is expected to cost millions of dollars because the government must start paying the minimum wage to public employees who have been earning less.

Officials also express fears of curtailed work by public safety employees, and cite the case of four D.C. homicide detectives whose investigation of a murder was cut short last week to avoid paying them overtime. The incident occurred shortly after police officials had circulated a memorandum outlining steps to comply with the ruling.

"There's an increasing degree of alarm about the costs and the disruption, both of which will be substantial," said the White House official.

Congressional hearings on the issue are scheduled for July 25, and three governors as well as a host of local officials are expected to raise the prospect of budget-busting expenses because of the ruling.

Groups such as the National Association of Counties and the National League of Cities also are increasing pressure on the Reagan administration to introduce legislation that would repeal overtime provisions of the Fair Labor Standards Act and effectively constrain the fiscal impact of the Supreme Court's ruling.

The White House official acknowledged that the administration is considering backing such a bill. Congressional aides say the measure would be opposed by organized labor, and would stand little chance of passage in the Democratic-controlled House of Representatives.

"What happens on the House side depends on how much pressure we can put up," said one Senate aide who would like to see the *Garcia* decision undone by Congress. "But politically I just don't think we can do it."

Susan Meisinger, deputy u secretary for employment dards in the Labor Departr said she believes legislation is able. "There's a growing con about the impact," she said. " happens depends on how hard and local governments push."

In a speech to the American Association last week, Atto General Edwin Meese III bl the court for the *Garcia* ruling claiming that it "undermines the bility" of state and local gov ments.

To comply with the ruling, Angeles will have to pay $100 lion a year; San Francisco, $30 lion, and New York, $40 million cording to Cynthia M. Pols, co to the National League of Citie

Many municipalities are in process of determining how m of their workers are covered by federal guidelines and how m are not. Some personnel offi acknowledge privately that in derline cases where there is r for discretion, governments tend to classify workers as exe from the law, and therefore i gible for premium pay.

State and local government officials also are afraid of the eff of a provision in the federal law allows employees to bring pr lawsuits to recover back overt pay. Because the court's ruling effective April 15, any munic worker who wants to collect o time since that date will be abl do so, along with a penalty doub the overtime payment.

Ironically, although labor u officials initially were elated by Supreme Court decision in Fe ary, some are now acknowled that their members are unha about losing compensatory time

APPENDIX F

TOTAL ASSETS AS OF 1/21/85 OF THE LARGEST NON-SOCIAL SECURITY SYSTEMS

California State Teachers	$ 12,300,000,000.00
Texas Teacher System	9,753,000,000.00
Ohio Public Employees	8,584,000,000.00
Ohio Teachers	8,507,000,000.00
Los Angeles County	4,394,000,000.00
University of California	4,200,000,000.00
Colorado Public Employees	4,108,000,000.00
Illinois Teachers	3,788,000,000.00
Mass. Employees & Teachers	2,400,000,000.00
Alaska State Systems	1,663,000,000.00
Illinois State Universities	1,581,000,000.00
Ohio Police & Firemen	1,559,000,000.00
Kentucky Teachers	1,485,000,000.00
Ohio School Employees	1,484,000,000.00
Los Angeles Fire & Police	1,449,000,000.00
Chicago Teachers	1,343,000,000.00
Louisiana State Employees	1,242,000,000.00
Nevada Public Employees	1,237,000,000.00
L.A. City Employees	1,061,000,000.00
L.A. Water & Power	1,000,000,000.00
Chicago Municipal Employees	896,000,000.00
Chicago Policemen	720,000,000.00
	$74,754,000,000.00

SOURCE: Pensions & Investment Age - January 21, 1985

These funds are ranked within the top 200 pension funds in the United States.

The effect upon local governments in Massachusetts, who have more employees, would be even greater. It is estimated that in 1986 alone, inclusion of all such employees in Medicare would cost local governments $60-70 million and their costs of including all new employees in the OASDI program would total $25 million.

While these figures do not reflect offsetting savings to the state resulting from mandatory social security coverage, Massachusetts officials note that such savings cannot be expected in the near future, at least with respect to Medicare.

Los Angeles County officials estimate that the current proposals would require $30 million in the first year. Of that amount, $18 million would be used to meet Medicare payments.[3]

From these examples, it is obvious that any plan that both includes mandatory social security coverage and maintains even approximately the present benefit level will impose significant additional costs upon the affected states.

2. The imposition of an additional fiscal burden upon state and local government comes at a particularly inappropriate time. A few months ago, the United States Supreme Court issued a decision requiring state and local governments to adhere to federal minimum wage and maximum hour laws. It has been estimated that this decision will cost state and local governments as much as $2 to $4 billion annually.

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[3] Los Angeles Times, August 10,1985, at CC-1, a copy of which is attached as Appendix C.

Included in the harsh impact of this ruling are Los Angeles, which will be required to pay an additional $100 million per year; San Francisco, which must pay $50 million; and New York, whose costs will rise by $40 million.[4] The governors of North Carolina and Missouri have estimated that this ruling will cost their states, respectively, $15 million and $8.2 million per year.[5]

Moreover, proposals currently before Congress would variously eliminate the deductibility of state taxes, eliminate revenue sharing, and limit the tax exemption of certain governmental bonds. As the chart attached as Appendix E illustrates, the cumulative effect upon the states of these proposals would be devastating.[6]

For example, while the current proposal to expand Medicare and OASDI coverage would cost Louisiana roughly $90-100 million annually, the combined cost of this and the other measures mentioned above would total $300-320 million annually.

4/ Information concerning the impact of this case , Garcia v. San Antonio Metropolitan Transit Authority, is found in The Washington Post, July 15, 1985, at A-1, a copy of which is attached as Appendix D.

5/ Hearings before the Subcommittee on Labor of the Senate Committee on Labor and Human Resources (July 25, 1985).

6/ The figures demonstrating the effect of elimination of the deductibility of state taxes are extracted from the May 31, 1985 "Governors' Bulletin," published by the National Governors' Association. The figures concerning the limiting of revenue sharing are extracted from Federal Funds Information for States newsletter, Volume II, Chapter 2, October 1984, at 22.

A range is reflected in the Medicare and Social Security column because two different sources were used to determine the number of employees outside the social security system. One number is from the 1982 census of governments. The other is from 1980 data published by the Social Security Administration.

similarly, for Texas the cost of the social security proposals would equal $160-200 million, but the total cost of those measures plus the current proposals to eliminate state tax deductibility and limit revenue sharing is $1.064 - 1.103 billion. And while the social security proposals would raise Missouri's costs by $28-43 million, the combined cost of all three changes would approximate $453-468 million.

While we recognize the urgency of the need to balance the federal budget, OPPOSE respectfully submits that state and local governments should not be forced to bear such a disproportionate and overwhelming share of the federal government's belt-tightening. Given the enormous burden of the Supreme Court's decision and of other congressional proposals, extension of mandatory social security coverage may well be likened to the straw that broke the camel's back.

3. Because of the cost increase entailed, enactment of mandatory social security coverage would interfere with the ability of state and local governments to attract and maintain quality employees. Some of the independent retirement plans, including that of Colorado, have been in existence since before enactment of social security. State and local governments have

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6/ (cont'd from previous page) To calculate the cost to the states, we used the following formula:
Cost = Number of Employees ($22,000) (.0145) plus (number of employees) (.09)($22,000)(.057)
.0145 = Employer contribution for Medicare
.09 = annual percentage of the work force that equals percentage of newly hired employees
.057 = Employer contribution for OASDI
$22,000 - Average salary of a State employee.

long used these plans as an important means of recruiting employees. Most of these plans have been specifically tailored to meet the unique needs of the individual employees recruited. For example, one important component of the employment package offered a police officer is a plan that offers generous disability and survivors' benefits. Without such benefits, it would become difficult indeed to attract and maintain a work force in such a hazardous line of duty. However, under mandatory coverage there would be great pressure to reduce those benefits. The cost increase resulting from mandatory social security coverage would offer affected governments a choice of raising taxes commensurately or of cutting benefits. In light of the other uncontrollable cost increases outlined above, we believe that the likely alternative for many states would be to reduce their employees' benefits.

The actuaries who administer Colorado's plan have determined that a new retirement plan maintaining constant costs and taking account of social security would require a delay in the retirement age for many workers, and the elimination of post-retirement increases, and disability and survivors' benefits. Thus, if mandatory coverage were enacted, Colorado would lose an essential ingredient of the employment packages it offers to attract capable workers. Similar results could be expected in other jurisdictions throughout the country.

As a result it would become extraordinarily difficult for state and local governments to attract workers to these positions.

4. Withdrawal of the funds of the independent retirement plans would have a negative effect on the nation's financial markets. The 22 largest non-social security retirement plans currently have assets of $74.754 billion. [7]. These funds are invested primarily in corporate stocks and bonds, federal treasury notes, and real estate mortgages. We believe that the diversion of these funds from the nation's capital markets to the pay-as-you-go social security trust funds could have a severe effect on the American economy.

5. Any apparent gains generated through mandatory social security coverage would, in fact, be illusory. Because the social security system actually consists of three independent trust funds, social security revenues may be used only to pay social security benefits. Any "revenues" generated by the current proposals for mandatory coverage could not be allocated for other purposes. Indeed, social security has been removed from the unified budget beginning in 1992 -- precisely so that savings to the social security trust funds will no longer

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7/ Pensions and Investment Age, January 21, 1985. A list of the largest non-social security funds is set forth as Appendix F.

appear to be savings to the general revenues.[8] At that time, the illusory revenues generated will not even show up in the budgetary process.

Of course, because newly covered employees would eventually begin to withdraw benefits, mandatory coverage would entail no significant long term savings to the social security trust funds. In fact, the National Commission on Social Security reform estimated the long-term savings to the OASDI funds to be quite small.[9] The long-term effect of mandatory coverage upon the HI fund has not been estimated.

6. There remain serious constitutional issues with respect to the mandatory social security coverage of state and local employees. Under the doctrine of intergovernmental tax immunity, the federal government is prohibited from "unduly interfering" with a state's ability to perform essential services. Because mandatory social security coverage would impose an overwhelming fiscal burden upon the affected states or strike a devastating blow to their ability to recruit employees, it would certainly interfere substantially with their performance.

8/ President Reagan has urged Congress to remove social security from the unified budget even earlier. The Washington Post at A6 (August 6, 1985) a copy of which is attached as Appendix G.

9/ *See* Report of the National Commission on Social Security Reform, Appendix K at Table A-4, reproduced and attached as Appendix H.

Moreover, the federalist structure of the Constitution and the tenth amendment limit the ability of Congress to intrude into areas reserved to the sovereign states. This rule has not been eliminated by Garcia v. San Antonio Metropolitan Transit Authority. Instead, that case specifically reserved the possibility of judicial review and substantive restraint upon Congress in areas where the political process failed to protect the interest of the states. If the current social security proposals are enacted, such a failure will have occurred; the majority of states and the national government will have attempted to solve their budgetary problem at the expense of the few states who will be disproportionately affected by these proposals.

7. Mandatory social security coverage, on a mere few months' notice, would cause an administrative nightmare. If the current proposals were adopted immediately, affected state and local governments would have only a few months to implement the program. Given the enormity of the task -- attempting to revise existing retirement and health insurance programs for millions of people -- such a short lead-time is inconceivable. Indeed, although it has been 2 1/2 years since Congress enacted mandatory coverage of federal employees, we note that no coordinated social security and civil service plan is yet in place.

Moreover, most governmental entities have long since made budget decisions and allocations concerning the period beginning in 1986. Of these, a significant number operate under balanced budget restrictions.[10] Given the early effective date of the current proposals, those governments may simply be unable both to comply with new social security requirements and to operate within their own constitutions.

* * * * * * * *

Many of our members' retirement plans predate the enactment of Social Security. Our plans are financially sound and offer generous benefits as a primary inducement to attract workers to essential positions in state and local government. For the reasons set forth above, we ask you not to destroy our retirement plans in a hasty attempt to raise illusory revenues.

Thank you for allowing me the opportunity to present the views of OPPOSE.

10/ For a list of those states with balanced budget requirements, see Appendix I.

APPENDIX A

TABLE 6-24. INCREASE IN TOTAL EMPLOYER-EMPLOYEE RETIREMENT COSTS (PLAN PLUS SOCIAL SECURITY TAXES) EXPRESSED AS A PERCENTAGE OF PAYROLL

		Constant-Benefit Step-Rate Plan	
Plan	Current Plan	Percentage-Point Increase Assuming 12.26% Combined Social Security Taxes	Percentage-Point Increase Assuming 15.30% Combined Social Security Taxes
		(percentage of payroll)	
Large plans		Mean 4.98%	Mean 7.88%
(1,000+ members)		Median 4.35	Median 7.55
H1 - t[a]	11.89%	5.58%	8.62%
H2 - p,f	14.83	6.38	9.42
H3 - g,t,p,f	16.81	4.21[b]	7.23[c]
H4 - g	16.27	1.83	4.87
H5 - g	12.72	5.45[b]	8.23[c]
H6 - t	18.92	3.60	5.64
L1 - g	7.82	9.78	12.82
L3 - g	14.39	3.66[b]	6.56[c]
L6 - g	15.68	4.35[b]	7.55
Medium-size plans		Mean 4.21	Mean 7.01
(100-999 members)		Median 4.33	Median 7.37
M1 - p	20.91	4.33	7.37
M2 - g,p,f	19.87	3.47	6.51
M3 - p,f	12.11	6.11[b]	9.25
M4 - p	19.15	5.00[b]	6.34
M5 - g,p,f	19.68	1.34[b]	3.84[c]
M6 - g,p,f	19.73	2.25[b]	5.27[c]
M7 - f	16.09	6.28	9.32
M8 - f	30.06	0.80	3.84
M9 - p,f	23.13	8.33	11.37
Small plans		Mean 4.72	Mean 7.75
(less than 100 members)		Median 6.70	Median 8.44
S1 - p	17.87	5.43	8.44
S2 - p,f	13.66	6.70	9.74
S5 - p	22.72	6.87	9.91
S6 - p	17.51	3.64	6.68
T1 - p	31.58	4.46	7.50
T3 - f	38.50	-1.00	+2.04
T4 - p,f	23.90	6.95	9.99

[a] In this coding, f = firefighter plan, g = general public employee plan, p = police plan, and t = teacher plan.

[b] Combined Social Security taxes somewhat below 12.26 percent because of salaries above the wage base.

[c] Combined Social Security taxes somewhat below 15.30 percent because of salaries above the wage base.

SOURCE: Calculated from AERF study data.

APPENDIX B

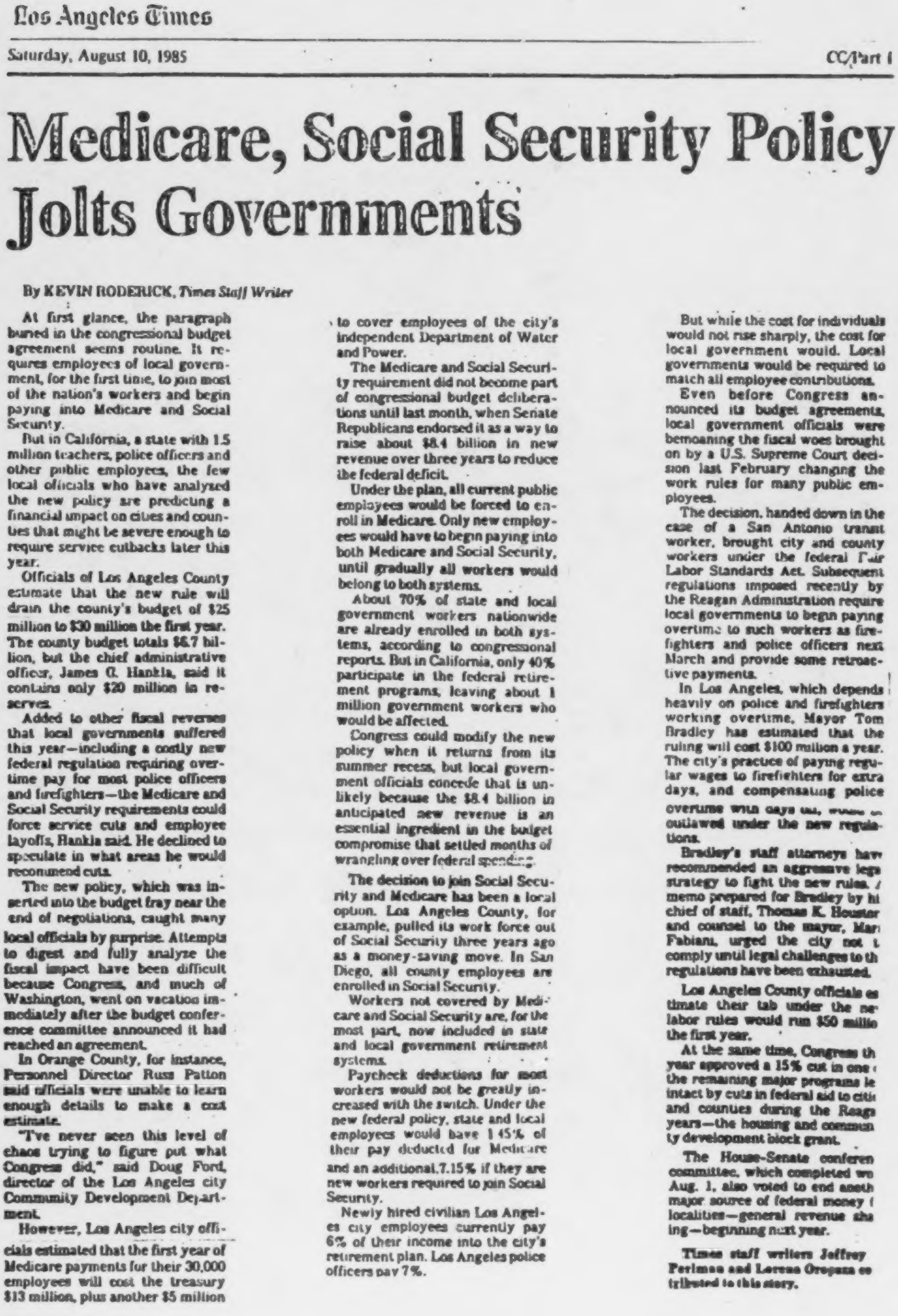
TABLE 6-35. INCREASE IN TOTAL RETIREMENT COSTS (INCLUDING SOCIAL SECURITY TAXES AND SUPPLEMENTAL COST) OVER TRANSITION PERIOD, IF NEW EMPLOYEES ONLY ARE BROUGHT INTO SOCIAL SECURITY

	Constant-Benefit Formula			Most Likely Formula		
Plan	Employer	Employee	Total	Employer	Employee	Total
			(percentage of payroll)			
Large plans						
H1 - t[a]	8.37%	2.65%	11.02%	9.74%	2.65%	12.39%
H2 - p,f	8.27	0.65	8.92	8.90	0.65	9.55
H3 - g,t,p,f	9.97	0.60	10.57	9.99	0.60	10.59
H4 - g	4.72	1.36	6.08	5.65	1.36	7.01
H5 - g	7.04	1.88	8.92	6.81	2.88	9.69
H6 - t	5.74	1.60	7.34	4.58	1.60	6.18
L1 - g	7.98	3.85	11.83	7.41	7.81	15.22
L3 - g	7.04	1.74	8.78	7.29	2.60	9.89
L6 - g	5.69	2.65	8.34	5.01	2.65	7.66
Medium-size plans						
M1 - p	6.36	3.65	10.01	3.97	3.65	7.62
M2 - g,p,f	5.95	1.65	7.60	6.65	0.65	7.30
M3 - p,f	-1.42	7.65	6.23	3.34	7.65	10.99
M4 - p	6.39	2.45	8.84	8.66	2.45	11.11
M5 - g,p,f	7.61	-0.67	6.94	7.61	-0.67	6.94
M6 - g,p,f	7.68	0.60	8.28	7.68	0.06	8.28
M7 - f	7.00	2.65	9.65	8.68	2.65	11.33
M8 - f	4.36	1.60	5.96	4.36	1.60	5.96
Small plans						
S1 - p	7.16	1.65	8.81	7.16	1.65	8.81
S2 - p,f	6.35	5.44	11.46	8.35	5.44	13.79
S5 - p	11.51	3.65	15.16	11.13	3.65	14.78
S6 - p	7.39	3.65	11.04	9.19	3.65	12.84
T1 - p	5.12	3.65	8.77	1.20	7.65	8.85
T3 - f	4.33	1.40	5.70	4.17	1.40	5.57
T4 - p,f	7.48	2.65	10.13	7.65	7.65	15.30

[a] In this coding, f = firefighter plan, g = general public employee plan, p = police plan, and t = teacher plan.

SOURCE: Calculated from AERF study data.

APPENDIX C



Los Angeles Times
Saturday, August 10, 1985 CC/Part I

Medicare, Social Security Policy Jolts Governments

By KEVIN RODERICK, *Times Staff Writer*

At first glance, the paragraph buried in the congressional budget agreement seems routine. It requires employees of local government, for the first time, to join most of the nation's workers and begin paying into Medicare and Social Security.

But in California, a state with 1.5 million teachers, police officers and other public employees, the few local officials who have analyzed the new policy are predicting a financial impact on cities and counties that might be severe enough to require service cutbacks later this year.

Officials of Los Angeles County estimate that the new rule will drain the county's budget of $25 million to $30 million the first year. The county budget totals $6.7 billion, but the chief administrative officer, James C. Hankla, said it contains only $20 million in reserves.

Added to other fiscal reverses that local governments suffered this year—including a costly new federal regulation requiring overtime pay for most police officers and firefighters—the Medicare and Social Security requirements could force service cuts and employee layoffs, Hankla said. He declined to speculate in what areas he would recommend cuts.

The new policy, which was inserted into the budget fray near the end of negotiations, caught many local officials by surprise. Attempts to digest and fully analyze the fiscal impact have been difficult because Congress, and much of Washington, went on vacation immediately after the budget conference committee announced it had reached an agreement.

In Orange County, for instance, Personnel Director Russ Patton said officials were unable to learn enough details to make a cost estimate.

"I've never seen this level of chaos trying to figure out what Congress did," said Doug Ford, director of the Los Angeles city Community Development Department.

However, Los Angeles city officials estimated that the first year of Medicare payments for their 30,000 employees will cost the treasury $13 million, plus another $5 million to cover employees of the city's independent Department of Water and Power.

The Medicare and Social Security requirement did not become part of congressional budget deliberations until last month, when Senate Republicans endorsed it as a way to raise about $8.4 billion in new revenue over three years to reduce the federal deficit.

Under the plan, all current public employees would be forced to enroll in Medicare. Only new employees would have to begin paying into both Medicare and Social Security, until gradually all workers would belong to both systems.

About 70% of state and local government workers nationwide are already enrolled in both systems, according to congressional reports. But in California, only 40% participate in the federal retirement programs, leaving about 1 million government workers who would be affected.

Congress could modify the new policy when it returns from its summer recess, but local government officials concede that is unlikely because the $8.4 billion in anticipated new revenue is an essential ingredient in the budget compromise that settled months of wrangling over federal spending.

The decision to join Social Security and Medicare has been a local option. Los Angeles County, for example, pulled its work force out of Social Security three years ago as a money-saving move. In San Diego, all county employees are enrolled in Social Security.

Workers not covered by Medicare and Social Security are, for the most part, now included in state and local government retirement systems.

Paycheck deductions for most workers would not be greatly increased with the switch. Under the new federal policy, state and local employees would have 1.45% of their pay deducted for Medicare and an additional 7.15% if they are new workers required to join Social Security.

Newly hired civilian Los Angeles city employees currently pay 6% of their income into the city's retirement plan. Los Angeles police officers pay 7%.

But while the cost for individuals would not rise sharply, the cost for local government would. Local governments would be required to match all employee contributions.

Even before Congress announced its budget agreements, local government officials were bemoaning the fiscal woes brought on by a U.S. Supreme Court decision last February changing the work rules for many public employees.

The decision, handed down in the case of a San Antonio transit worker, brought city and county workers under the federal Fair Labor Standards Act. Subsequent regulations imposed recently by the Reagan Administration require local governments to begin paying overtime to such workers as firefighters and police officers next March and provide some retroactive payments.

In Los Angeles, which depends heavily on police and firefighters working overtime, Mayor Tom Bradley has estimated that the ruling will cost $100 million a year. The city's practice of paying regular wages to firefighters for extra days, and compensating police overtime with days off, [illegible] outlawed under the new regulations.

Bradley's staff attorneys hav recommended an aggressive lega strategy to fight the new rules. / memo prepared for Bradley by hi chief of staff, Thomas K. Houster and counsel to the mayor, Mar Fabiani, urged the city not t comply until legal challenges to th regulations have been exhausted.

Los Angeles County officials es timate their tab under the ne labor rules would run $50 millio the first year.

At the same time, Congress th year approved a 15% cut in one the remaining major programs le intact by cuts in federal aid to citi and counties during the Reag years—the housing and commun ty development block grant.

The House-Senate conferen committee, which completed wo Aug. 1, also voted to end anoth major source of federal money localities—general revenue sha ing—beginning next year.

Times staff writers Jeffrey Perlman and Lorenzo Oropeza co tributed to this story.

APPENDIX E

Financial Impact Upon the States of Proposals Currently Under Consideration in Congress ($ in Millions)

	State Tax Deductibility	Revenue Sharing	*Expanded Medicare and Social Security Coverage	Total
Alabama	$195	$76.4	up to $18.7 million	up to $290.1 million
Alaska	20	21.9	8.2 - 11.8 million	50.1 - 53.7 million
Arizona	220	55.3	10.4 - 12.8 million	285.7 - 288.1 million
Arkansas	114	46.2	2.6 - 11.9 million	162.8 - 172.1 million
California	3,838	507.4	356.5 - 366.2 million	4701.9 - 4711.6 million
Colorado	338	54.4	61.8 - 65.5 million	454.2 - 457.9 million
Connecticut	423	54.0	29.4 - 31.1 million	506.4 - 508.1 million
Delaware	97	13.2	3.5 - 5.2 million	113.7 - 115.4 million
Washington,D.C.	124	17.7		141.7 million
Florida	528	166.6	34.1 - 48.4 million	728.7 - 743.0 million
Georgia	490	109.9	36.3 - 41.6 million	636.2 - 641.5 million
Hawaii	116	21.6	2.4 - 6.9 million	140.0 - 144.5 million
Idaho	63	19.4	.9 - 4.0 million	83.3 - 86.4 million
Illinois	1,154	210.0	170.1 - 170.6 million	1534.1 - 1534.6 million
Indiana	279	85.6	16.8 - 38.1 million	381.4 - 402.7 million
Iowa	219	54.2	3.0 - 11.6 million	276.2 - 284.8 million
Kansas	193	38.3	7.3 - 12.1 million	238.6 - 243.4 million
Kentucky	240	74.8	26.3 - 31.7 million	341.1 - 346.5 million
Louisiana	134	83.3	90.7 - 100.4 million	308.0 - 317.7 million
Maine	79	28.3	19.9 - 21.3 million	127.2 - 128.6 million
Maryland	791	87.5	9.1 - 18.4 million	887.6 - 896.9 million
Massachusetts	894	128.7	127.3 - 146.4 million	1150.0 - 1169.1 million
Michigan	1,310	192.5	20.7 - 77.5 million	1523.2 - 1580.0 million
Minnesota	621	89.6	37.6 - 40.8 million	748.2 - 751.4 million
Mississippi	101	60.2	up to 17.8 million	up to 179.0 million
Missouri	345	79.8	28.5 - 43.3 million	453.3 - 468.1 million
Montana	33	20.1	3.5 - 6.6 million	56.5 - 59.7 million
Nebraska	138	30.7	3.5 - 8.7 million	172.2 - 177.4 million
Nevada	50	14.3	19.0 - 20.7 million	83.3 - 85.0 million
New Hampshire	64	14.2	2.2 - 5.7 million	80.4 - 83.9 million
New Jersey	1,241	146.2	up to 61.9 million	up to 1449.1 million
New Mexico	52	32.2	8.6 - 14.0 million	92.8 - 98.2 million
New York	4,089	461.8	31.1 - 199.8 million	4581.9 - 4750.6 million
North Carolina	464	120.9	13.0 - 27.4 million	597.9 - 612.3 million
North Dakota	28	13.0	5.6 - 9.3 million	46.6 - 50.3 million
Ohio	885	189.5	243.0 - 260.0 million	1317.5 - 1334.5 million
Oklahoma	271	57.6	12.5 - 24.2 million	341.1 - 352.8 million
Oregon	311	54.8	7.3 - 15.7 million	373.1 - 381.5 million
Pennsylvania	985	219.0	8.6 - 53.0 million	1212.6 - 1257.0 million
Rhode Island	111	20.2	5.5 - 5.6 million	136.7 - 136.8 million
South Carolina	235	68.8	3.5 - 13.4 million	307.3 - 317.2 million
South Dakota	14	14.7	2.6 - 6.4 million	31.3 - 35.1 million
Tennessee	153	83.0	15.5 - 38.6 million	251.5 - 274.6 million
Texas	661	239.8	163.0 - 202.3 million	1063.8 - 1103.1 million
Utah	143	36.3	4.3 - 8.2 million	183.6 - 187.5 million
Vermont	39	12.0	.9 - 4.49 million	51.9 - 55.49 million
Virginia	620	98.7	up to 13.4 million	up to 732.1 million
Washington	271	74.0	1.7 - 14.5 million	346.7 - 359.5 million
West Virginia	66	44.7	3.5 - 7.7 million	114.2 - 118.4 million
Wisconsin	651	107.7	23.3 - 40.5 million	782.0 - 799.2 million
Wyoming	17	15.8	3.5 - 3.9 million	36.3 - 36.7 million

*On January 1, 1986, all current employees and new hires would be included in Medicare. After January 1, 1986, all new hires would be in the Social Security system.

APPENDIX G

TRANSCRIPT OF PRESID

I wanted to take this opportunity to look back, as well as ahead to our expectations for the fall; 1985 is shaping up as a year of progress. The economy is in good health, America is at peace and helping to push forward the frontiers of freedom.

We can draw confidence from seeing interest rates still trending down, an inflation rate that is still remaining under 4 percent and nearly 600,000 jobs created this year.

And now, with the economy's batteries recharged, we're setting forth with new zest. The road ahead looks clear to a strong job market with no new tax increases to slow us down and no dark clouds of inflation on the horizon.

But there's much we can and must do to make this a better year.

We intend to launch a major fall offensive, going to the people and working with Congress to achieve major, much-needed reforms.

We will intensify our efforts for budget reform, for a line-item veto—which 43 state governors already have—and for a balanced-budget amendment finally mandating Congress may spend no more than it takes in.

We cannot reduce chronic overspending by Congress with a mere carrot of friendly appeals to good intentions. We must also be able to bear down with a rod of real discipline.

We'll also devote special attention to the areas of farm and trade, which have great impact on the budget and the health of our economy.

Come Labor Day, we're going to pull out all the stops for passage of tax reform. We cannot abide the injustices and disincentives in the current code. We must replace it with a new system offering lower marginal tax rates and greater fairness for the American people. For the sake of our future, there is no higher, nor more pressing, priority.

On the legislative front, we didn't get all the savings we sought, but we held firm on principle and we did succeed, which I consider crucial, in attacking budget deficits not by reducing the peoples' earnings but by reducing government spending. Many appropriations bills will be coming up, and I'm looking forward to examining each one with my veto pen hovering over every line.

In foreign affairs, we've turned the tide of gradual Soviet expansion so evident five years ago. Our alliances are stronger, and we have regained our position of leadership, working to resolve the international debt burden, carrying the flag for the spread of democracy, and seeking real gains on key global issues from human rights to nonproliferation.

At Geneva, we are in the best position in more than a generation to achieve real reductions in nuclear weapons. All we need is a serious approach by the Soviets. I look forward to meeting with General Secretary [Mikhail] Gorbachev in Geneva this November.

Looking elsewhere, we've begun rebuilding our defenses, our conventional forces are stronger, Congress has supported our strategic modernization program and our deterrent is stronger. But we must press on to complete that program.

We're also going forward with research on our non-nuclear Strategic Defense Initiative, holding forth the great hope that we may one day protect the people of this planet from the threat of nuclear attack.

And we achieved a breakthrough when Congress recognized the importance of Central America to our national security by voting to assist the freedom fighters

BY LARRY MORRIS—THE WASHINGTON POST

Reagan meets reporters for a televised news conference for the first time since his cancer surgery July 13.

But let me point something else about Social Security. Social Security as a part of the deficit is nothing but a bookkeeping gimmick. Social Security runs a surplus. By incorporating it into the budget, you then add to the budget the outgo and the income. But with that surplus, this apparently reduces the size of the deficit.

But the Social Security payroll tax goes into a trust fund and cannot be used for anything else. Not one penny of it can be used to reduce the deficit in the overall management of government. To continue to say that this could somehow reduce the deficit by reducing Social Security benefits is a snare and a delusion. And that's why I believe that we shouldn't even wait until 1992 when it is slated to be taken out of the budget and made a separate program.

It originally was, and it was during the Johnson years that Social Security was incorporated into the budget for the very purpose of making the deficit then look smaller than it was.

You mean LBJ would do that?

What? Oh, he had help up on the Hill.

A question about South Africa.

All right.

Do you intend to continue your policy of "constructive engagement," or do you think the time is quite near when you might have to take some action such as sanctions?

And we achieved a breakthrough when Congress recognized the importance of Central America to our national security by voting to assist the freedom fighters in Nicaragua.

The cause of freedom is the cause of peace. And I commend all those in Congress who voted to support the pro-freedom movements in Nicaragua, Afghanistan and Cambodia and to repeal the Clark amendment that banned help for the freedom fighters in Angola.

So, as I said, we've begun well, but we have much more to do.

Some of the Senate Republicans feel you really pulled the rug out from under them, that you really did not go for a big deficit cut and that you are going to face a very tough time. Your statement's very rosy, but that isn't the outlook that's coming from the Hill.

There may be some who feel that way. But, before they left town, Bob [Senate Majority Leader Robert J.] Dole [R-Kan.] came over late in the afternoon, and we had a good meeting up there and were in agreement that, yes, the budget resolution that we got was not as much as we had hoped. A compromise never is. But we think it came very close to the figures that—well, in some instances, were even greater than the figures that I had first proposed in February. And we were in agreement also, and Bob agreed, that the Senate and I—the Senate Republicans, we could be working together. And I'm hoping that it'll continue to be a bipartisan effort.

But the figures that came out of the two houses—the $56 billion or $57 billion—are being challenged by the Congressional Budget Office and by some of the legislative leaders who say the first-year savings won't be anywhere close to that. Do you think that next year, a congressional election year, you can do any better in actually eliminating programs, as you first proposed?

We're going to try. We're going to try to get—well, in other words, let's say over this three-year projection we have to make, I have never believed that what we agree to now is the final for the next three years and that we're frozen in. We're going to continue trying to eliminate programs that have outlived their usefulness and are no longer serving a worthwhile purpose, and some things that the government never should have been doing in the first place. And I think that there will be some pretty sizable support for that because, even though it's an election year, I think most in Congress know that the No. 1—every poll shows this—the No. 1 concern of the people of the country today is the deficit and the overspending by government. So, I think that they'll be aware of that.

Do you think real budget—real deficit—reduction is possible without getting into the entitlement area, which you have put off the table with the [House] speaker?

Let me point something out about the entitlement area. One of the reasons—I didn't pull it off. We had a meeting out here in the patio, outside the office one day, with the leadership of both houses and both parties. And at that meeting, the Democrat leadership made it plain that as far as they were concerned Social Security was off the table, nonnegotiable.

Now at that time, the meetings, the conference had broken up. There were no longer any conference meetings going on to try and bring a conference resolution. When the proposal was then made again from the Senate with regard to Social Security COLAs [cost-of-living allowances] and the tax increase, I immediately called Bob Dole and told him that that there was no way that I could support a tax increase. I think this would be counterproductive with regard to spending cuts and all. And I told him also that I thought we had all, were aware that we couldn't go back into conference if it was based on Social Security COLAs. That had been taken off the table.

or do you think the time is quite near when you might have to take some action such as sanctions?

I believe the results that we've had in this constructive engagement with South Africa justifies our continuing on that score. Obviously, and as we have made very plain, we all feel that apartheid is repugnant. Now this is the actual participation on a more equitable basis of the black citizens of South Africa. But if you look at the gains that have been made so far by our so-called constructive engagement, the increase in complete biracial education, the fact that American businesses there have, over the last several years, contributed more than $100 million to black education and housing, the fact that the ban on mixed marriages no longer exists, that some, I think 40-odd business districts have been opened to black-owned businesses, labor union participation by blacks has come into being, and there has been a great desegregation of hotels and restaurants and parks and sport activities and sports centers and so forth.

There are other things I haven't—I cannot list them all here—but all these have been coming about as they have continued to work toward what is the final answer. And I think just recently, and over the weekend the words of [Gatsha] Buthelezi, who is the leader of the Zulus, and they are a full third or more of the black population of South Africa—and he has come out against the idea of hostility, of sanctions and so forth, and said what we have said, that things of that kind would only hurt the people we are trying to help.

So you are going to veto the bill?

I never say what I am going to do until the . . . .

Sometimes you do.

. . . thing gets to my desk, but I am going to say that in principle I have to say what I have said—that our continuation of our present program, I think, is the best way that we can be of help to the black citizens of South Africa.

But this is the third week of the state of emergency in South Africa. Your administration has called for it to be lifted, and yet there have been no results on that. What are you going to do to make that point more forcibly to the South African government?

We are going to continue, as I say, and we have—we think we have had some influence so far and they have themselves guaranteed that they want to make progress in that direction. You are talking though now about a governmental reaction to some violence that was hurtful to all of the people. We have seen the violence between blacks there, as well as from the law enforcement, against riotous behavior. I think we have to recognize sometimes when actions are taken in an effort to curb violence.

Would you veto the bill, as it now appears to be going to pass the Senate and has passed the House?

Let me wait until I see what comes to my desk. I know that in some of the things that we are talking about in that legislation were things that could be helpful in the very way that I have been talking. I know also, however, that the sanctions would not only be harmful to the black citizens there, they would be harmful to the surrounding black countries whose economies greatly depend on their trade and economic relations with South Africa.

So would it be fair to say that there'll be no change in U.S. policy, nothing to get tougher?

It depends on what you mean by change; if you mean by turning to the thing of sanctions and so forth, no. But there can be fluctuations in your conversation and your

NT'S NEWS CONFERENCE

relationship with another government.

What do you think about the conservative attacks upon Secretary [of State George P.] Shultz as being insufficiently anticommunist?

I think that they are without foundation, and they're utterly ridiculous. And I have every confidence in Secretary Shultz and that he is carrying out the policies that I believe in.

Could you give us, in view of your recent medical adventure, a little update from top to bottom, so to speak? And your nose?

I'm glad that you finally got around to that subject and asked that question.

You didn't think we would, did . . . .

What? No, I was worrying that—you can see, just like Lyndon [Johnson], I left my scar exposed here. And I know that you've all been losing a lot of sleep over the last several days about my nose.

We worry about you.

Yes. So, if I can, let me give you an update on this. So far, all the statements that have been made by [White House spokesman] Larry [Speakes] and by myself, by others have been the truth as we knew it. And I'm coming to a correction now, but we did not know it at the time.

It is true. I had—well, I guess for want of a better word—a pimple on my nose. And the doctors have a word—papule. That sounds nicer than the first one. But I violated all the rules. I picked at it, and I squoze it and so forth and messed myself up a little bit.

But it was, seemed to be getting a little better when I went into the hospital. And, then, after the operation when they put that tube in through my nose and down to my innards, they taped on the side of my nose quite heavily to hold that in place. I happen to have an allergy to adhesive tape. I can wear a Band-Aid maybe overnight or something but not that kind. And when, finally, they took it off and removed the tube, why, I was quite swollen and inflamed all around here.

And, then, my little friend that I had played with began to come back. So, after three days—well, or—no, I'm getting three days in the wrong place here. After, I went over, well, when I went over to the doctor for my weekly allergy shot, I called attention to this matter. And it was snipped off. And, then, I wore a patch—there's where the three days come in—for about three days before you all noticed it in the East Room. And I was surprised that no one had paid any attention to it or maybe you were just being polite.

But I'd heard some talk when they—it only took a couple of minutes—I'd heard some talk about possible, and they wanted to look at it for possible infection because of the irritation around there. But I did not know until this weekend at Camp David. I was informed that it had been examined, and it was indeed a basal cell carcinoma, which is the most common and the least dangerous kind. They come from exposure to the sun. Nancy had one removed above her lip some time ago. They're very commonplace. They do not betoken in any way that you are cancer-prone.

It is a little heart-breaking for me to find out, though, because all my life, I've lived with a coat of tan, dating back to my lifeguard days. That's why I didn't have to wear makeup when I was in movies. But now I'm told that I must not expose myself to the sun anymore. And, you know, I don't mind telling you all this because I know that medicine has been waging a great campaign to try and convince people to stop broiling themselves in the sun because of this very ailment. And so, if I can contribute any by saying here I am a veteran all my life, and it took a long time for it to finally have an effect, but for others to give up their dreams of a good tan. Because evidently it is, this is what causes it.

Does this condition require you to undergo any other examination?

No. No further examination, no further treatment of ny kind. It's gone, and, as I say . . . .

meant and wasn't. I didn't know about the other until this weekend at Camp David.

As a matter of fact, I hope you'll all recognize that at Camp David I decided that when I came back that I would either make that as an opening statement at this mini press conference or let you ask a question about it, and when it . . . .

It was on the tip of our tongues.

When it seemed to have disappeared from view, I thought I'd wait for you to ask a question about it.

Does the basal cell carcinoma mean skin cancer, or what's that . . . .

It is—well, carcinoma, the very word—is a form of cancer. This is the, as I say, the commonest, the least dangerous. It is not known as becoming or spreading or going someplace else, and it's, and it is virtually totally caused by the sun, exposure to the sun.

How soon will you be riding a horse?

I'm hoping to be riding a horse when I get to California next week.

In the shade . . . . You know that Gorbachev said that we were barbaric to drop the atomic bomb. What do you think of that?

I always thought it was barbaric of [Soviet leader Joseph] Stalin to kill some 20 million people in his own country, of his own countrymen.

But we dropped the bomb in an effort to end what had been the greatest war in man's history. The resistance of the enemy and the island campaigns leading up to an invasion of Japan was such that we knew we would be facing that kind of to-the-death resistance. The casualties were estimated at more than a million if we continued. And I think to second-guess now those who had to make that awesome decision is ridiculous. I think, horrible as it was, we have to say this, too—that it did give the world a view of the threat of nuclear weapons. And I think that should be an aid in one day now ridding ourselves of them. But I think we have to recognize that that and the presence of our nuclear weapons as a deterrent have kept us at peace for the longest stretch we've ever known—40 years of peace.

On a related point, why won't you go along with Gorbachev's suggestion for a joint moratorium on nuclear testing?

All right. That's the last question, all right. But I'm delighted to answer that one, too.

The Soviet Union is ahead of us in the development and the modernization of nuclear weapons. They have just finished their tests, or they even have a couple left they might try to sneak in before the 6th, which was their opening day. But they had finished their tests on their 24s and 25s, the 18 which is comparable to our MX. And we have not yet begun the testing and certainly haven't completed it in some of our weapons of that same type to keep pace with them.

So their suggestion for a mutual—first of all, for a single moratorium for several months—they finished their tests. They don't have any more to do. The asking us to make it mutual meant that we would then not be able to catch up with them. And we've had an example of that back in the Kennedy era.

And this had to do with the testing with regard to ABMs and so forth. And we were begging for a treaty, and the Soviet Union kept refusing. And they'd completed the test and then the Congress passed a go-ahead for us. And the Soviets immediately said to President [John F.] Kennedy, "Oh, yes, we're willing to talk now about a moratorium on testing."

So this was—this is why we said to them, "Look, we still have our tests to do, same ones that you've been doing. You're welcome to send somebody over and watch all our tests."

And we, I would like to add also that after that limited moratorium which was supposed to end around December or something, if they want to make that a permanent moratorium or if they want to agree with us and have bilateral inspection of each other's testing.

Does this condition require you to undergo any other examinations?

No. No further examination, no further treatment of any kind. It's gone, and, as I say . . . .

What about your overall health?

Overall health is . . . .

Since the operation.

Very good. I am amazed myself at, when I look at the length of the incision—which I won't shew you—and all, that I feel as good as I do.

We had some trouble getting information about your nose last week. And I wonder, to what extent do you think the American people have a right to know about your full condition and your full health and welfare?

No, as I told you, we thought we were giving you all the truth on it, that it was just exactly as I described it. And it wasn't until after I was up at Camp David that the report came to me that it was that mild form, the carcinoma . . . .

But we were told . . . .

. . . commonplace thing.

. . . we were told . . . . Does basal cell carcinoma mean skin cancer?

I think that where life and death or ability to do jobs is concerned, yes, the people have a right to know whether the man sitting at this desk is—or woman sitting at this desk is— . . . .

Good catch.

. . . capable of performing the tasks. And, on the other hand, I think there can be invasions that go beyond the need to know that. And I think we were trying to tell you as much as we could what we believed was the truth.

The—you see, when you put out a statement—the White House put out a statement. They said, "This is it." And we were never told what it was.

Well, that I'd messed around with a pimple and caused some trouble for myself.

But we were not told that there was a biopsy.

What?

We were not told that there was also . . . .

I didn't know.

. . . a biopsy.

I didn't know. All, as I say, all I heard, as I was sitting up and getting ready to walk out of the office, was the one, the doctor mentioned the fact that he needed to check this for possible infection, that it might have become infected from not only my messing around but from the tape and all. And that's all I heard and what it

[illegible] moratorium, which was [illegible] December or something, if they want to declare that a permanent moratorium or if they want to agree with us and have bilateral inspection of each other's testing, we're willing to do that.

You said watch all our tests? You would go for a total moratorium, permanent moratorium on all underground tests? All tests? At the end of the year?

Once when—well, I don't know whether we'd be able to complete ours by that time or not. When we've completed ours, and they're not doing any more . . . .

They say we've . . . .

. . . yes, that would be fine.

. . . completed ours in Nevada.

What?

I understand our tests have been completed.

Oh, no. We're still talking about a Midgetman to match their 24 or 25. And we haven't even come to that stage yet.

When might that be? Within a year or . . . .

I don't know. I don't know. But, in the meantime, let's get back down to real facts. In Geneva is where the decision should be made and not with moratoriums of that kind. Let's get down to the business once and for all of reducing the numbers of nuclear weapons, hopefully leading toward a total elimination of them. Then there wouldn't be any need for testing.

Thank you, sir. Thank you, Mr. President.

All right. Well, it's nice to see you all. Where have you been keeping yourselves?

You should do this more often.

What?

You should do this more often.

I always enjoy it.

What are you going to do if there's a baseball strike?

Well, I'm not going to go to the ball game.

Do you have any views on the baseball strike?

I don't think government should intervene in labor-management affairs of any kind. But I do think that all parties really should sit down there with the fans in their minds and their obligation to the baseball fans.

Thank you, sir.

'Bye.

We'll be watching you ride the horse.

Yes, I know. From way up on the mountain.

A-4 Extend coverage to all new State and local employees, effective 1984.**

	Cost (in billions of dollars)							
Estimate	1983	1984	1985	1986	1987	1988	1989	1983-89
II-B, OASDI	0	-.3	-1.1	-1.8	-2.6	-3.3	-4.2	-13.3
III, OASDI	0	-.3	-1.0	-1.8	-2.6	-3.5	-4.5	-13.7
II-B, HI	0	-.1	-.2	-.5	-.7	-.9	-1.1	-3.5
III, HI	0	-.1	-.2	-.5	-.7	-.9	-1.1	-3.5

25-Year Cost, OASDI: -.23% of taxable payroll
50-Year Cost, OASDI: -.28% of taxable payroll
Long-Term Cost, OASDI: -.24% of taxable payroll

25-Year Cost, HI: -.23% of taxable payroll

TABLE 92--STATE FISCAL DISCIPLINE MECHANISMS

STATE	TAX AND EXPENDITURE LIMITATIONS	BALANCED BUDGET REQUIREMENT	REQUIRE SUPER-MAJORITY VOTE TO PASS TAX	INDEX INCOME TAX	GUBERNATORIAL LINE-ITEM VETO	FISCAL NOTE REVIEW PROCEDURE	PROGRAM EVALUATION & SUNSET	"RAINY DAY" FUNDS
TOTAL	18	49	7	10	43	41	29	24
New England								
Connecticut		X			X	X	X	X
Maine		X		X			X	
Massachusetts		X			X	X		
New Hampshire		X				X	X	
Rhode Island	X	X				X	X	X
Vermont							X	
Mideast								
Delaware		X	X		X		X	X
Maryland		X			X	X	X	
New Jersey		X			X	X		
New York		X			X			X
Pennsylvania		X			X	X	X	
Great Lakes								
Illinois		X			X	X	X	
Indiana		X				X	X	X
Michigan	X	X			X	X		X
Ohio		X			X	X		X
Wisconsin		X		X	X	X		
Plains								
Iowa		X		X	X	X		X
Kansas		X			X	X	X	
Minnesota		X		X	X			X
Missouri	X	X			X	X		
Nebraska		X			X	X		X
North Dakota		X			X			
South Dakota		X	X		X	X		
Southeast								
Alabama		X			X	X	X	
Arkansas		X	X		X	X		
Florida		X	X		X	X		X
Georgia		X			X	X	X	X
Kentucky		X			X	X		X
Louisiana	X	X	X		X	X	X	
Mississippi		X	X		X	X		X
North Carolina		X				X		
South Carolina	X	X		X	X	X	X	X
Tennessee	X	X			X	X	X	X
Virginia		X			X	X		X
West Virginia		X			X	X	X	
Southwest								
Arizona	X	X		X	X	X	X	
New Mexico		X			X	X	X	X
Oklahoma		X			X		X	
Texas	X	X			X	X	X	
Rocky Mountain								
Colorado	X	X		X	X	X	X	X
Idaho	X	X			X	X		X
Montana	X	X		X	X	X	X	
Utah	X	X			X	X	X	
Wyoming		X			X	X	X	X
Far West								
California	X	X	X	X	X	X		X
Nevada	X	X				X		
Oregon	X	X		X	X	X	X	
Washington	X	X			X	X	X	X
Alaska	X	X			X		X	X
Hawaii	X	X			X		X	

NOTE: In several cases, the measure has been adopted by a state, but not yet implemented.

SOURCE: 1984 ACIR Survey of Executive and Legislative Fiscal Officers.

TABLE 93--RESTRICTIONS ON STATE AND LOCAL GOVERNMENT TAX AND EXPENDITURE POWERS (OCTOBER 1984)

States	State Imposed Limits on Local Governments							
	Overall Property Tax Rate Limit	Specific Property Tax Rate Limit	Property Tax Levy Limit	General Revenue Limit	General Expenditure Limit	Limits on Assessment Increases	Full Disclosure	Limits on State Governments
Total Number	12	31	21	6	6	7	13	18
Alabama	CMS***	CMS*						
Alaska	CMS**		CM**					Const.***
Arizona			CM***		CMS***	CMS***		Const.***
Arkansas		CMS*	CMS***1/					
California	CMS***				CMS***	CMS***		Const.***
Colorado		CS*	CM*		S**		CMS***	Stat.**
Connecticut								
Delaware		S**	C***1/					
Dist. of Col.								
Florida	CM***	CMS*					CMS**	
Georgia		S*						
Hawaii							C**	Const.***
Idaho		CMS*	CMS***					Stat.***
Illinois		CMS*					CMS***	
Indiana			CMS***					
Iowa		CM*				CMS***	CMS*	
Kansas		3/	CM**		S**			
Kentucky	CMS*	CMS***					CMS***	
Louisiana		CMS**	CMS***1/					Stat.***
Maine								
Maryland				CM***		CM**	CM**	
Massachusetts			CMS***					
Michigan	CS*	M*	CMS***				CMS***	Const.***
Minnesota		S*	CMS**	M**	S**			
Mississippi		CMS*	CMS***	CMS***				
Missouri		CMS*		CMS***				Const.***
Montana		CMS*					CMS**	Stat.***
Nebraska		CMS*		CMS***5/				
Nevada	CMS*	S*	CM**					Stat.***
New Hampshire								
New Jersey			C**		MS**			
New Mexico	CMS*	CMS**	CMS***			CMS**		
New York		CMS*				CM***2/		
North Carolina		CM**						
North Dakota			CMS***					
Ohio	CMS*		CMS**1/					
Oklahoma	CMS*	CMS*						
Oregon			CMS*			CMS***		Stat.***
Pennsylvania		CMS*4/						
Rhode Island			M				M	Stat.**
South Carolina								Stat.***
South Dakota		CMS*						
Tennessee							CMS***	Const.***
Texas		CMS**					CMS***	Const.***
Utah		CMS*						Stat.***
Vermont								
Virginia							CM**	
Washington	CMS**	CMS**	CMS**	S**				Stat.***
West Virginia	CMS*	CMS*						
Wisconsin		CMS*						
Wyoming		CMS*						

C--County M--Municipal S--School District *--Enacted before 1970 **--1970 to 1977 ***--1978 and after
Const.--Constitutional Stat.--Statutory

See notes on next page.

1/ Limits follow reassessment. 2/ Applicable to only New York City and Nassau County. 3/ Only for selected districts (Fire, Library, Cemetery, etc.) 4/ Jurisdictions with home rule charters are not subject to limits. 5/ Expires December 31, 1984.

Source: ACIR staff calculations based on surveys of state revenue departments.

U.S. Advisory Commission on Intergovernmental Relations

The CHAIRMAN. Next we will take Mayor Bolen.
Mr. Mayor.

STATEMENT OF HON. BOB BOLEN, MAYOR, FORT WORTH, TX; ON BEHALF OF THE NATIONAL LEAGUE OF CITIES

Mayor BOLEN. Mr. Chairman, members of the committee, I am Mayor Bolen from Fort Worth, TX, representing the National League of Cities.

I would like to add that I came up last night from our own budget hearings that we have to put to bed September 15. So you can see that we have a timeframe ourselves. I will be back in session this evening in Fort Worth.

The reason I mentioned that is because we are having the same difficulty you are, we understand that, and we appreciate the conditions that you have and that we have.

We want to go on record again as a group and as my city is on the record, supporting the effort to balance the budget before we do a tax reform package or anything else. We think that the budget deficit is the No. 1 problem that this country is addressed with, it is one that is going to affect all of us in not only the long term but the short term.

We also notice that there have been extraordinary cuts in Federal assistance to the cities, and yet the deficits have gone from roughly $30 billion to $200 billion a year. So, we find that, although we are sacrificing in many ways—and I can give you several specific instances—none of those seem to have helped address the deficit problem. We want you to know that we are paying the price to get that done.

Yesterday our city council had an hour debate on picking up $300,000 worth of child dental assistance that we have inherited from the Federal Government. We used to have that financed from community block grant funds. We will pick up that cost ourself. We have had 4 years of tax increases in a city that is in very good economic condition compared to most.

We have had to add a penny to our sales tax to support our transit system. So, like the gentlemen on my left, we are doing our share; but we don't think that we should carry the entire burden.

We are struggling right now over the *Garcia* decision. How should we handle it? Like one of the other speakers mentioned, this court decision has a major impact on our citizens, in finding a way to fund the increased personnel costs dictated by this decision.

All added together, these actions put a burden on the cities that frankly we cannot handle. And then you top this by requiring Medicare coverage and say that we are going to pick that up right away in the middle of our fiscal year, when I am proposing tomorrow or the next day, a 7-cent increase in our tax rate and not even knowing what we are going to contend with, and it is not going to be difficult to address—it is going to be impossible to address in our current budget.

We are fortunate that our budget calendar is much later in the year than most of the cities' budgets in this country.

The impact of the Medicare proposal alone will be $1.6 million to Fort Worth, TX, which is equal to a little over 1 penny on the tax rate. We are already going up between 6 and 7 cents like I mentioned.

For Dallas the cost will be $4.5 million. For San Antonio the cost will be $1.2 million. All of these additional costs with no time for preparation.

Now, if the Congress is given 2 years to phase in similar proposals for Federal workers, how are we going to phase these programs in the next 4 days? And that is exactly what I have to do. It is an impossibility.

One of our other concerns are tax revision proposals affecting Geo bonds. The current proposals will impact us greatly.

For all of these programs we are willing to carry our fair share; but we don't believe that we can pick up the entire revenue increase that you are looking at through our participation in the Medicare Program.

The tax assumptions that you are looking at are all going to be borne by the cities.

Last, I would like to say that presently the programs you have dropped, we are able to pick up. The phaseout of revenue sharing is different, it is one of the most effective ways that you can deliver dollars to the cities. The southern cities in the State of Texas are being hit by all sorts of problems that are not of their own making. Immigration is a major one. Devaluation of the peso is another. I happen to have some businesses on the border, and every time the peso is devalued, the next day it severely impacts the sales tax revenues of those cities—not a month from now, not a year from now, but tomorrow afternoon. And if we don't have some way to mitigate that impact on those cities, those cities will be in a disastrous shape in the very near future. Revenue sharing has been a way to partially mitigate some of those impacts.

Thank you very much for letting me be here today.

The CHAIRMAN. Thank you, Mr. Mayor. We appreciate it.

Now we have Mr. Sam Diannitto. I see you are accompanied by Harold Schaitberger. He doesn't have a nameplate in front of him, but I have dealt with him for years in his representation of the firefighters, and I find him one of the most able people and able representatives of his organization that I have run across.

Mr. SCHAITBERGER. Thank you.

[Mayor Bolen's written testimony follows:]

STATEMENT

OF

BOB BOLEN, MAYOR OF FORT WORTH, TEXAS

Good morning Mr. Chairman and members of the Committee. My name is Bob Bolen. I am the Mayor of Fort Worth, Texas, and I am here this morning representing the National League of Cities - the largest and oldest organization in the country representing publicly elected officials of the nation's cities.

I am grateful for the opportunity to present our views before your panel this morning. The National League of Cities concurs with the Chairman's statement about the priority of federal deficit reduction: we believe it is the single greatest priority facing the nation, and until substantive action can be taken, we believe it inappropriate to be considering any tax reform proposal which does not deal responsibly with the growing national debt.

In our view, both the president's budget recommendation to the Congress and the Congressional budget resolution fall short of the necessary steps to achieve real deficit reduction and to alleviate related problems to the economy. We commend the bipartison efforts by the Senate Budget Committee, including members of this committee, who participated in spurned efforts to make much more significant savings than those eventually accepted.

Budget Impact on Cities

For cities, the budget process of the last 5 years has been especially difficult. While extraordinary cuts have been made in federal assistance to cities, the deficit has risen from less than $28 billion to over $200 billion. While cities have been asked, repeatedly, to sacrifice, it has become increasingly clear that our sacrifices have not been used to reduce the deficit, but merely to contribute to dramatic increases in other uses of federal resources.

We have called for, and will continue to call for a balanced deficit reduction effort. We believe that all federal expenditures must contribute - including tax expenditures. We have indicated our support in earlier testimony for the legislation submitted by Sen. Chafee, and we continue to believe it is critical to balanced and fair deficit reduction despite the adverse impact it would have on our own ability to raise capital at the municipal level.

Reconciliation

The instructions to this committee call for both significant spending cuts and federal tax increases. The instructions assume that this committee will take legal action to terminate the single most important and efficient form of federal assistance to cities, and assume that the entire federal tax increase will come from state and local governments.

We take issue with both sets of assumptions.

Revenue Sharing

Revenue sharing is to be terminated under the assumptions at its expiration under current law. It is unclear how the committee can comply with instructions to end a program in FY1987 that no longer exists.

For cities, however, there is no more important program. It is the one program that recognizes that not all cities have equal fiscal capacity, and that no two cities have exactly the same needs in the way they use their own revenue sources.

In effect, we view revenue sharing as a program through which wealthier and more fortunate local governments share their tax base with poorer and less fortunate local governments.

Our society is founded in part on the assumption that not every family is equally able to help itself. We, as a nation, have always believed that a helping hand ought to be extended to those most in need.

Revenue sharing is not dissimilar. There are cities in Nebraska that will no longer be there in a few years. Cities in the southern part of my state are amongst the most distressed in the nation - not through their own deeds, but by events largely beyond their own control. I am talking about cities with extraordinary levels of poverty, unemployment, and immigrants. These are cities where the tax base has simply withered - they, quite simply are not in a position to help themselves.

While there has been substantial discussion in this committee about whether revenue sharing assistance has been directed as well as it could be according to criteria of fiscal distress, there has never before been a decision that the federal government has no role to play in seeking a fiscal balance amongst the nation's states and local governments.

We believe the federal role to be fundamental, and we believe that this committee, perhaps more than any other in the Congress, has always accepted this role in the past. We hope it will continue to, and that we will be able to work with you.

Federal Tax Increases

In addition to the $22 billion in spending cuts under this committee's jurisdiction, the committee has been called upon to increase federal taxes some $8.4 billion over the next 3 years. The instructions to this committee are distinct from the instructions given to your companion committee in the House, creating greater uncertainty for states and local governments which must take steps to comply with any new mandates or spending cuts.

While the instructions leave it entirely up to this committee how it should increase federal taxes by that amount, the resolution assumes that a new tax will be directed solely to states and local governments and their employees. It assumes that this federal revenue increase will take place in the middle of the current state and local budget years. It makes no assumptions about how cities, with their budgets already in place, will make the transition from current health insurance and retirment systems to one mandated by the federal government.

Mandatory Coverage for State and Local Governments

The National League of Cities opposes the proposal of mandatory participation in Social Security and Medicare. For those of us who have structured our own retirment systems in reliance on the existing federal system and law, the proposal would be a severe penalty. It would come not only in the middle of one of the harshest budget years cities have faced, but at the same time as cities are attempting to determine how to comply with the U.S. Department of Labor wage and hour regulations for municipal employees - regulations estimated by the White House to cost us $1.5 billion a year. The proposal comes at a time when we are struggling to raise our own revenues to accomodate the likely loss of revenue sharing.

We believe we have made significant contributions to reducing the federal deficit over each of the last five years. The budget this year provides for, in the words of Chairman Domenici, "unparalleled" cuts in state and local assistance. The budget does not, however, call for any contribution from the long list of wealthy corporations with little to no federal tax liabilities. It is hard to imagine real and fair deficit reduction unless everyone is willing to participate and contribute to the process.

We are, quite simply, ill equipped to respond to such an expensive mandate, and I strongly urge you to reject it.

The proposal to raise these new revenues from states and local governments creates a number of questions:

First, since Social Security and Medicare are financed by dedicated trust funds, and since this committee is considering the proposal by Sen. Heinz to take Social Security out of the unified budget, what impact would the proposed tax increase on cities have on reducing the federal deficit?

Second, when the Congress terminated the right of states and local governments to voluntarily withdraw from Social Security in 1983, it specifically precluded preempting the rights of states and local governments from retaining their own pre-existing health insurance and retirement systems. What has changed since the Social Security bipartison commission recommendations to support mandating state and local participation, particularly given the current and projected surpluses in the Social Security trust fund?

Third, the budget assumes that these tax increases will take effect at the end of this year - the middle of the fiscal year for almost all cities. Yet, when the Congress determined that coverage should be mandatory for federal employees, it provided a two year transition period, both to enable transition to a new retirement system, and to accomodate budget costs. Why has no consideration been given to permitting states and cities a transition period in which to restructure our plans and determine how much state and local taxes will have to be increased to meet this federal mandate?

Specific Impacts of the Proposal on Cities

There is no question that cities will be heavily impacted financially by proposals to abruptly mandate membership in the Medicare/Social Security System.

The City of Fort Worth, Texas, relying upon the National government's commitment to a voluntary system of Retirement Security for state and local governments, has structured its own independent retirement system and has never belonged to the Federal Social Security System.

If the Congress were to mandate coverage under Medicare for all employees, the annual cost to the City of Fort Worth would be $1.6 million and the city would be compelled to unilatrally reduce the take-home pay of its employees by the same amount.

The cost to our sister cities in Texas will also be large. The Medicare proposal alone would cost the City of Dallas $4.5 million annually and San Antonio $1.2 million.

Our city is required by charter to adopt its annual budget by September 15. That budget must be balanced. In a sense, you might say we are fortunate; most cities in this country have already adopted their budgets, and any federally mandated changes will force disruptions. For my city, if these proposals are enacted, the city will have an extremely limited amount of time to adjust.

Employees in the city currently have 7.67% deducted from their salaries to help finance the retirement program while the city contributes 11.5%. Social Security coverage would instantly almost double the retirement deduction for a new employee and increase the city's contribution by 62% for the same individual.

The impacts of this added cost will strike cities and other jurisdictions throughout the United States. Federal estimates of $8.4 billion of trust fund revenue to be raised over three years are dollars which will not be available to provide state and local government services.

If just the immediate Medicare provision were adopted, California cities would be responsible for paying $64.5 million in additional costs and of reducing their employees take-home pay by a similar amount. Statewide California jurisdictions and their employees would be paying $471 million more in retirement taxes.

The City of Portland, Oregon would be required to cover police and fire employees not currently covered at an annual cost of $1.95 million.

Kansas City, Missouri would be faced with additional costs of $940,000 to cover its police officers and firefighters and St. Louis with additional costs in excess of $1 million.

In addition, all school districts in Missouri would be faced with added costs of $14.5 million with the teachers facing a similar reduction in take-home pay.

While the impact varies from employer to employer, the impact of this proposal is clearly national.

State and local governments have preceeded in good faith to develop and administer retirement systems and many have chosen to make Social Security and Medicare a part of their programs. For those public employers who have not, however, the current proposals will interfere with existing contractual arrangements such as retirement plans and employee contracts. It will leave open to question just who is responsible for determining how local property taxes are to be spent in the nation's cities - the federal government, or the officials publicly elected by the property tax payers to make those decisions.

I am very grateful for the opportunity to present our views, and I would welcome the opportunity to respond to any questions you might have.

STATEMENT OF SAM DIANNITTO, JR., PRESIDENT, NATIONAL CONFERENCE OF PUBLIC EMPLOYEE RETIREMENT SYSTEMS, LOS ANGELES, CA

Mr. DIANNITTO. Mr. Chairman and distinguished members of the Committee, my name is Sam Diannitto, and I am president of the National Conference on Public Employee Retirement Systems. We are a national retirement association comprised of over 240 State and local retirement plans, representing over 5 million members with approximately $300 billion in assets.

At this time I was going to introduce Harold, but the chairman did such an outstanding job that I think I will bypass the introduction.

We appear today to discuss a serious proposal which was considered during the recent congressional action on the fiscal 1986 budget, adopted by the Congress before it adjourned for its August recess.

It should be stated that NCPERS is deeply concerned about the current Federal deficit and supports the Congress in its attempts to reduce it. But also, NCPERS strongly opposes the mandatory inclusion of State and local government employees, both current and future, who are not presently covered by the Social Security or Medicare programs.

It is important to note that NCPERS strongly supports a Social Security program. Approximately 70 percent of current State and local government employees are covered by the program, which is integrated or dovetailed with their own retirement systems.

The Congress has addressed the proposition of mandatory coverage several times over the last dozen years, and each time, in its wisdom, has determined that such a consideration was neither feasible nor appropriate.

In economic terms, the direct results of mandating Social Security or Medicare coverage would be an increase in taxes for governments and their employees. I would also have a serious negative impact on the national economy. At the same time, mandated coverage would make no significant contribution to the Social Security system or the Medicare Program as a whole and will create future financial problems.

It has been suggested that mandatory Social Security would help in the reduction of the current Federal deficit. In fact, it would lead to increased costs for governments at all levels and their employees, and it will result in increased taxes for the general public.

A case in point. My home city of Los Angeles—the cost for fiscal year 1987 would be an additional $32 million. That burden would have to go someplace, and it would eventually be passed on to the taxpayers, or a reduction in services provided to the residents of the city.

Some of the most serious effects of mandatory Social Security coverage would be on the Nation's economy. The effects on capital formation will be great. State and local retirement systems contribute significantly to capital formation. The figure is estimated at approximately $30 billion a year. Mandatory Social Security and Medicare coverage would drastically cut the availability of these investment moneys.

The phasing out of independent retirement programs, which can be anticipated, will lead to a loss of all such capital.

It appears to us that Congress is unwisely looking toward mandatory Social Security and/or Medicare coverage as a method of generating short-term revenues. We believe this conclusion is shortsighted. Although mandating coverage would add funds to the system in the short run, in the long run it will increase liabilities as newly covered employees become eligible for benefits.

Many State and local systems predate Social Security. Comtemporary pension plans in uncovered States usually were designed on the assumption that coverage under Social Security would not occur. Many employees of the States and political subdivisions have existing pension or retirement rights which are guaranteed by contract and/or State law. In some States, such as New York, Michigan, Illinois, and Alaska, contractural obligations regarding public employee pension plans are preserved in the States' constitutions. Approximately 35 States provide some kind of benefit guarantee, either by specific constitutional provision, a provision of State retirement law, or court decision. Mandating coverage will now cause tremendous problems for those systems which cannot alter or modify their current systems without due legislative process.

And last, before the yellow light goes out, we would ask the question whether the administration still maintains the same position on mandatory Social Security today that it did on June 1, 1981. And I would like to read a very short paragraph of a letter to the Honorable Paul Laxault from President Ronald Reagan, where it says:

> Dear Paul, I would like to reaffirm my position regarding the issue of mandatory enrollment of State, county, and municipal employees into the Social Security pro-

gram. I share your concern that congressional legislation to mandatorily enroll these employees would create a substantial financial hardship to the State and local governments involved. More important, a merger may jeopardize the hard-earned benefits of dedicated career public employees.

And I think that that sums up our position in a nutshell.

I thank you for the extended time, Mr. Chairman.

[Mr. Diannitto's written testimony follows:]

STATEMENT OF SAM DIANNITTO, PRESIDENT OF THE NATIONAL CONFERENCE ON PUBLIC EMPLOYEE RETIREMENT SYSTEMS

Mr. Chairman and distinguished members of the committee, my name is Sam Diannitto, and I am President of the National Conference on Public Employee Retirement Systems, a national retirement association comprised of over 240 state and local retirement plans representing over 5 million members and managing approximately $300 billion in assets.

We appear today to discuss a serious proposal which was considered during the recent congressional action on the fiscal 1986 budget (Senate Concurrent Resolution 32) adopted by the Congress before it adjourned for its August recess. It should be stated at the outset that NCPERS is deeply concerned about the current federal deficit and supports the Congress in its attempt to reduce it.

During the deliberations between the House and Senate Budget Committees, the proposal for extending social security and medicare coverage and to state and local government employees, currently excluded from coverage, was offered in several forms. The first such proposal was passed out of the U.S. Senate by one vote in its Budget Resolution on May 10, 1985. This resolution contained a proposal to include all newly hired state and municipal employees in both the social security program and the medicare program. A proposal resembling the Senate's recommendation passed out of the House of Representatives Ways and Means Committee on July 23, and 24, 1985. This proposal, however, only extended medicare coverage to state and municipal employees hired after January 1, 1986. The Budget Committee Conference, in the final days before the August recess, agreed to instruct the Senate Finance Committee and the House Ways and Means Committee to raise $8.4 billion in revenues over the next three fiscal years.

Although the resolution did not specify how the revenues were to be generated, it is clear that their assumptions were based on the extension of coverage to state and local government employees into the medicare and social security programs. Those assumptions would require coverage for all current and future state and local workers into the HI portion of the social security system and OASDI coverage for all new hires effective January 1, 1986.

NCPERS strongly opposes the mandatory inclusion of state and local government employees, both current and future, who are not presently covered by the social security or medicare programs, into the social security system by the United States Congress.

It is important to note that NCPERS strongly supports the social security program. Approximately 70% of current state and local government employees are covered by the program which is integrated or dovetailed with their own retirement systems. The Congress has addressed the proposition of mandatory coverage several times over the last dozen years and each time, in its wisdom, has determined that such a consideration was neither feasible nor appropriate. In economic terms the direct results of mandating social security or medicare coverage would be an increase in taxes for governments and their employees. It would also have serious negative repercussions on the national economy. At the same time, mandated coverage would make no significant contribution to the social security system or the medicare program as a whole and may even create future financial problems.

It has been suggested that mandatory social security would help in the reduction of the current federal deficit. In fact, it would lead to increased cost for governments at all levels and their employees, which most probably will result in increased taxes for the general public.

I would also like to remind you that the Congress extended social security coverage to federal employees in 1983 and now over two years later Congress is still trying to develop and implement the retirement program for these employees covered under the social security program. The difficulty in providing such an integrated program will only be multiplied by the hundreds of local government jurisdictions which would be faced with the same difficult exercise. Any equitable program of mandatory coverage would have to guarantee that benefits already being offered by public retirement systems be maintained. In order to achieve comparable coverage a combination of social security and existing retirement systems will be necessary. In addition to the tremendous administrative, regulatory and legislative nightmare that this will create for local and state government, the financing of such a combined retirement system would only lead to higher cost for both the public employee employer.

Some of the most serious effects of mandatory social security coverage would be on the nation's economy. The effects on capital formation will be great. State and local retirement systems contribute significantly to capital formation. The figure is estimated at approximately $30 billion a year. Mandatory social security and medicare coverage would drastically cut the availability of these investment monies. The phasing out and reduction of independent retirement programs which can be anticipated, will lead to a loss of all such capital.

In previous Congresses, supporters of mandatory coverage often pointed to the abuses of the social security system by some as a justification for mandating coverage, however, Congressional action in 1981 and 1983 adequately address those concerns and eliminated perceived loopholes with the spouse offset and windfall benefits reduction as it applies to public workers.

It appears to us that the Congress is unwisely looking toward mandatory social security and or medicare coverage as a method of generating short term revenues. We believe this conclusion is short sighted. Although mandating coverage would add funds to the system in the short run, in the long run it will increase liabilities when newly covered employees become eligible for benefits.

It is additionally important to look at the history of the social security program when considering these proposals. Originally public workers were excluded from social security coverage. In 1956 they were granted the opportunity to elect social security coverage by amendment to the Social Security Act. It was felt then that only a voluntary measure would meet the standard that prohibits federal taxation of a state governmental function.

Because of the immunity principle of state and local governments from federal taxation, the social security employers tax, in our opinion, cannot be imposed. The 1956 amendment provided for social security coverage only by referendum of the employees and only upon a state governor's certification that the new overall benefit would be an improvement. Only in this way could the state obligate itself to pay social security employers taxes. We submit that this should be maintained.

I would point out that the legislative history of this and other types of elected coverage provisions show that Congress sought to prevent a state or local authority from unconscionably phasing out its retirement system in order to adopt a social security plan. Congress indicated additonally that the states could be obligated to pay the social security employers tax only by their own voluntary action, and not by federal mandate.

Many state and local systems predate social security. Contemporary pension plans in uncovered states usually were designed on the assumption that coverage under social security would not occur. Many employees of the states and political subdivisions have existing pension or retirement rights which are guaranteed by contract and or state law. In some states such as New York, Michigan, Illinois, and Alaska contractual obligations regarding public employee pension plans are preserved in the states' constitution. Approximately 35 states provide some kind of benefit guarantee either by a specific constitutional provision, a provision state retirement law or court decision. Mandating coverage will now cause tremendous problems for those systems which cannot alter or modify there current systems without due legislative process.

In conclusion, NCPERS believes that mandating social security or medicare coverage will at best generate some short term revenues. Such proposals will create serious legal questions which will ultimately be answered in the courts. Mandating coverage will cause serious administrative regulatory and legislative problems for local and state governments who will be required to develop new retirement programs. The liabilities for such a consideration far outweigh the assets.

Therefore, we ask that your committee reject any propoposal for mandated coverage in the social security and medicare programs for state and local government employees.

The CHAIRMAN. Let me ask all except Mr. McAuley—and I have some separate questions for you in a moment—a question of fairness.

We brought the Federal employees under Medicare on January 1, 1984, partially because we discovered the General Accounting Office report indicated that 72 percent of Federal employees were going to receive Medicare benefits, either from other employment or from coverage derived from their spouses. And we have premised the Medicare payment system on the assumption that there will be any number of dual earners, but they will only get one benefit. And it is the same benefit. In fact, if your spouse doesn't work in the marketplace his or her entire life, he or she will collect the same Medicare benefits you will.

What is unfair? Let's just take a guess. I am going to assume the same percentage of local employees probably would have derivative Medicare coverage from someplace else—from a spouse, or they would have worked in private enterprise and have been covered. Why should only municipal and State employees be exempt, at least on the question of Medicare coverage, from paying a portion of the cost of the benefits to which they are going to become entitled, when anybody else employed in other than local or State employment would be paying part of those costs, even though they may have derivative coverage from someplace else? Why uniquely leave off local employees?

Mr. SCHAITBERGER. Mr. Chairman.

The CHAIRMAN. Go ahead.

Mr. SCHAITBERGER. Well, I would take a shot at that, Mr. Chairman.

First of all, it seems to me that if employees are paying for coverage through any source of employment, that they, therefore, should be entitled to the benefit, whether that employment occurs as a job in addition to their current employment or whether it occurs because of post-retirement.

The CHAIRMAN. Let me rephrase it, because I may not have phrased the question right.

Mr. and Mrs. Jones. Mr. Jones works for ARCO, and Mrs. Jones works for the bank. They each pay into Medicare. And yet, when they reach eligibility, Mrs. Jones, had she never worked for the bank, would get Medicare coverage, because Mr. Jones had it. And they are private employees, both of them.

But we are premising pay-in pay-out of Medicare on the assumption that any number of people are going to be employed and pay into the system, even though they would be covered if they weren't employed. But we do it so that it comes out actuarily sound.

Why should Mrs. Jones pay into the system if she works for the bank all of her life, even though she doesn't need to pay in because she would be covered by her husband's employment, but not pay in if she works for the city of Denver all of her life? What is the difference in fairness?

Mr. MAGEE. Mr. Chairman.

The CHAIRMAN. Yes.

Mr. MAGEE. Let me simply say this: As I see it, you have provided a question that needs some attention; but I think that should be addressed after there is a study and an opportunity for those of us at the State and local level to take a look at it to come up with some answers, and it shouldn't be done in context of a quick-fix effort to deal with the deficit.

In other words, if this is a problem, a Social Security system problem, let's address it that way; let's set up some kind of commission as the one that was set up and reported in 1983 on Social Security, and deal with it that way rather than a context of deficit reduction.

The CHAIRMAN. Let's not fool ourselves. I don't mean to fool you, and you certainly are not trying to fool me. This is not a deficit-solving issue.

Mr. MAGEE. No.

The CHAIRMAN. We have a $200 billion deficit, and these are nickels and dimes, comparatively speaking, in this $200 billion deficit.

I was thinking more in terms of the issue of fairness. Why do certain employees get Medicare benefits even though they never will pay anything into it, because they happen to work for a municipal government; whereas, exactly the same person, situated working for private employment, will pay Medicare taxes all of his or her life and be eligible for benefits, but eligible not because he or she paid them but because their spouse paid them?

Mr. SCOTT. Senator Packwood.

The CHAIRMAN. Yes, sir.

Mr. SCOTT. I think that is a valid question, and I think that you dealt with the larger question of the basic OASDI annuity in a way that this Medicare question could be dealt with also. You have an offset provision for Social Security that came in as a result of the 1983 legislation. I would suggest you might want to go back and look at that for Medicare.

I know, for example, I have put in 64 quarters of Medicare and 64 quarters of Social Security. I don't think I will ever draw a dime of the full annuity because of the offset and because I don't need it. So, you have had some of the dollars from some of these people. The system was set up so that, if you have a primary wage earner and the other spouse is not working, both spouses receive Medicare benefits. And we just seem to be in a situation where some State employees are benefiting from that provision. But I think this question is something that should be looked at.

The CHAIRMAN. Mr. Mayor.

Mayor BOLEN. Yes.

Senator, one of the things I had heard on this subject was the question you asked. I asked our city staff to check this yesterday afternoon. The results they reported were so different from what I thought they would be that I asked them to go back and reaffirm the statistic they reported.

Out of 1,000 employees that we checked, 10 percent are going to be qualified to receive Medicare.

The CHAIRMAN. Is that right?

Mayor BOLEN. Yes, sir.

The CHAIRMAN. That is amazing.

Mayor BOLEN. I asked that question twice, and I will document it when I get back home, but that is what I was told.

I think from Fort Worth's viewpoint and that of most of the cities that this concern about double dipping or whatever you want to call it, is going to have to ge addressed in the future

The fact remains that the main issue we have today is how do we take care of it by Monday morning in Fort Worth, TX? That is the issue I am here to address. I can't accommodate that cost in the next 4 days.

From the same standpoint, you have spouses all over the country that don't contribute anything and are not working that are still going to benefit. So, that is another issue.

The CHAIRMAN. That is a decision we made years ago as a matter of social policy.

Mayor BOLEN. Yes.

The CHAIRMAN. We simply said the fact that your spouse does not work in the marketplace, works at home for nothing instead of in the marketplace for money, all of his or her life, he or she will still get the same Medicare benefits you do.

Mayor BOLEN. Well, I am certainly not going to argue with that, after having five kids and adopting one and having four foster sons, my wife would kill me.

The CHAIRMAN. If you were to say she doesn't work?

Mayor BOLEN. That's right. [Laughter.]

The CHAIRMAN. Mr. Diannitto.

Mr. DIANNITTO. We would agree with Mr. Magee that this is an item that should be studied. And we realize that there may be some inequities in it, and it should be studies in depth. But it shouldn't be, you know, taken on as a proposal as a quick fix to anything. And that's the way we see it here today.

The CHAIRMAN. This is not a quick fix. Again, we are fooling ourselves if we think this is the answer to the deficit. If this was the whole answer to the deficit, we'd do it in a minute. It is not.

Mayor BOLEN. I hope so.

The CHAIRMAN. I wish we could solve the deficit this way; it would be wonderful. I think it is more of a question of fairness and a certain concept in the public's mind of: Why isn't everybody covered by Social Security? This is the argument we got about Federal employees over and over and over. Of course, you are aware of the battle we had before we brought Federal employees under it. And we have not yet harmonized the two systems, as a matter of fact, but we brought them under Social Security.

Isn't there an advantage to your employees if they are covered under Social Security from the standpoint of vesting and portability, as opposed to the lack of that situation, or at least of immediate vesting in their present employment?

Mr. SCOTT. Senator Packwood, I think vesting is an issue that could be dealt with by public pension funds, and so could portability. And I think it also could be dealt with in the private sector with those pension funds.

Obviously, there is portability with Social Security, and in some of our funds we don't have it. But there are some tradeoffs, and some of the tradeoffs are that we are doing an awful lot with fewer resources in many, many instances, and I think that more than makes up for the portability issue.

The CHAIRMAN. Your point was very good earlier that at least in Colorado, apparently, your retirement system is actuarily balanced. Is that right?

Mr. SCOTT. For the most part. We have an unfunded liability that is being amortized over I think about 22 or 23 years, and because of good investment performance the amortization period has come down, and we have added a supplemental health insurance program for our retired people who are not covered by Medicare.

The CHAIRMAN. Very good.

Now, Mr. McAuley, let me ask you this question. The State Social Security divisions are responsible for collecting the Social Security taxes from every little village, every little municipal corporation, every little fire district, and what not. I mean, assuming they are covered. Right?

Mr. MCAULEY. That is correct.

The CHAIRMAN. And these divisions are legally responsible for collecting that. We hold you responsible for that.

Mr. MCAULEY. That is correct. That is part of the section 218 agreement.

The CHAIRMAN. That is part of the great advantage to us, that we don't have to deal with 67,000 miscellaneous local units that have chose, for whatever reasons, to be covered by the system; you have to deal with them.

Mr. MCAULEY. That is correct, Mr. Chairman. That was one of the main reasons we were created, to relieve the Federal Government of the responsibility of dealing directly with each political subdivision of each State.

The CHAIRMAN. Just on the surface, and basically it is a method of contracting out, and just on the surface it strikes me, from our standpoint, as a much more efficient way of collecting the Social Security taxes, and especially with your very generous offer in response to Senator Moynihan's question of your statement on the interest.

Mr. MCAULEY. It has worked very well, Senator.

The CHAIRMAN. But I think it is important for everyone to understand that if, by some negligence of your own, you don't collect the taxes, we are still going to hold you responsible and get them out of you one way or another.

Mr. MCAULEY. That is correct; we are 100-percent liable regardless of the reason.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Then, as a followup on what Senator Packwood just said, do you think that the IRS could come close to the collection effort if it were turned over to them to do, as now the Social Security has the responsibility to do?

Mr. MCAULEY. I don't think there is any question, based on the studies conducted by the GAO, that Internal Revenue Service's major problem in the past and currently is the collection of income and Social Security tax. They, by their own admission, do not prosecute all delinquencies. In the States, there is no such animal. We prosecute any delinquency to fulfillment through our Attorney General's office. I don't think the two agencies can be compared. One guarantees 100-percent liability, while the other publicly States that they don't prosecute all delinquencies.

Senator **Grassley**. OK.

I would ask the panel a general question. I think I heard a little bit of Mr. Scott's testimony, and you may have touched on this:

Do you feel that the pension rights of State and local government employees covered by independent retirement plans would be adequately protected if Congress would approve mandatory Social Security coverage?

And then let me ask, additionally, along the same line, do you think it would be inevitable that benefits would have to be reduced at some point down the line if that were to happen?

You can start if you want to, but I know you did touch on it a little bit.

Mr. **Scott**. Yes, Senator Grassley. I think benefits are high because of the structure of our funds and the way they are set up, and the fact that we prefund and provide retirement based on investment earnings. If you take us out of that arena and we can't do that any more we are back into a situation where money comes from one pocket and goes into another. And I think that the more you focus in on that kind of thing, the more that you pass on this intergenerational debt, and the less that you really can provide decent improved benefits as a result of good investment performance and prefunding and prefunding retirement.

It seems to me that the kind of programs we've got ought to be copied rather than dismantled, because nobody wins when these funds are dismantled.

Mayor **Bolen**. Senator, in the case of my city, we wouldn't have any choice after we adopt this budget. The employees would actually get a reduction in pay, or else we would have to find some windfall to pay the cost somewhere else, and I haven't found too many such windfalls recently. We are mandated to have a balanced budget by State law. Once we adopt that budget, which we will do next Monday then that fund is locked in for the next year. So it would mean that we would actually say, "Employee, you are going to pay this much more for at least the next fiscal year." It is going to come right out of their pocket; we don't have any other place to get it.

Senator **Grassley**. I see.

Mr. Magee.

Mr. **Magee**. Senator Grassley, I would point out that, although the constitutions and laws of many of these States would guarantee retirees—present retirees and future retirees, even—that they would receive a certain monthly benefit, that any action by Congress that would impose additional costs on the system would tend to knock out the ability of those systems to provide cost-of-living increases. And in many instances those are of great importance.

So, although the basic benefit would continue, the system would be unable to bring about cost-of-living increases if the proposal now before Congress is adopted. And that would be one adverse impact, as I see it, on many of the systems.

Mr. **Schaitberger**. Senator, I think there would be two immediate effects. First, in those systems where benefits were not guaranteed by city charter, State constitution, or the State legislature, which could be modified more easily, benefits would be reduced, clearly, so as to merge with the Social Security Program.

More likely, though, there is going to be a considerable increase in costs, because the majority of systems will not be able to modify their programs, and immediately diminish their benefits, and will be faced with a salary increase of payroll of about 7 percent plus just for the city, not counting the emloyees' share. But certainly increased costs would come first, and diminished benefits would immediately follow.

Mr. **Diannitto**. I would say the burden to the employee would be a homegenized system. For example, in the city of Los Angeles, new employees pay 8 percent of their wages into their pension system which is actuarily funded, and they have guaranteed benefits. And they know that they are going to get those benefits when they retire.

If you put Social Security on top of that, now, they will be paying 15 percent out of their pockets to maintain the same benefits, with a portion of it not really being guaranteed when they get ready to retire and are going to depend upon the money from that retirement plan.

Senator **Grassley**. I have no further questions.

The **Chairman**. Gentlemen, I have no other questions. But, Mr. Mayor, could you get me a copy of that study about the 10 percent with derivative medicare coverage?

Mayor **Bolen**. Yes, Senator.

The **Chairman**. The reason I say that is I just assumed that if Federal employment was 72-percent derivative coverage, local would be within a percent or two of it. It is an amazing difference.

Mayor **Bolen**. Senator, like I said, I just asked for that yesterday. I reaffirmed the number, but I want to go back and look at it. But that is the number we received, and I will get it for you.

The **Chairman**. I really would like to get it within the week if I could, because we are going to be doing a markup on this whole subject within a week or 10 days.

Mayor **Bolen**. Yes, sir.

The **Chairman**. Thank you very much.

Mayor **Bolen**. Thank you very, very much. We appreciate being with you.

The **Chairman**. Gentlemen, thank you.

[A letter from Mayor Bob Bolen follows:]

THE CITY OF FORT WORTH
TEXAS

BOB BOLEN
MAYOR

September 12, 1985

The Honorable Bob Packwood
Chairman, Senate Finance Committee
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Packwood:

The purpose of this letter is to provide you with more specific information concerning testimony I gave before the Senate Finance Committee on September 11, 1985, concerning City of Fort Worth retired employees and their eligibility for Social Security Medicare and Medicaid Benefits.

The information, provided by the Risk Management and Insurance Administration Division of the City's Personnel Department, indicates that approximately 15% of 960 retirees surveyed in 1983 were eligible for Social Security benefits; 57 employees were eligible because of their spouses. This survey was conducted by our staff and the representatives from Alexander and Alexander, our insurance consultant, to determine if the costs of retirees' health insurance provided by the city could be reduced if a large percentage of retired city employees were eligible for the Social Security medical coverage.

Obviously with the results of this 1983 survey indicating a low number of retired employees eligible for such benefits, the City has continued to provide health insurance coverage for its employees upon retirement. This year, the retirement system is budgeting $1110 per retiree ($1.2 million) to cover the cost of their medical insurance; retirees must pay for their dependent coverage.

I regret this information is not current; however, a cursory review of our records Thursday reaffirmed that the number of City of Fort Worth retirees currently eligible for Social Security medical benefits is still significantly less than the 90% figure mentioned at the hearing Wednesday.

We appreciated the opportunity to be with you on Wednesday and hope this additional information will be of assistance to you and the Committee in making your decision.

Sincerely yours,

Bob Bolen

Bob Bolen
Mayor

BB:sm

The CHAIRMAN. We will now take a panel of Mr. Kenneth Kumm, James Landry, William St. John, Joseph O'Connor, and Lawrence Gross.

We will start with Mr. Kumm. And again I might request that you do as the other witnesses have done, put your entire statement in the record and abbreviate your testimony to stay within our 5-minute rule.

Mr. Kumm.

STATEMENT OF KENNETH KUMM, CHAIRMAN, JOINT INDUSTRY GROUP AND DIRECTOR OF CUSTOMS AND TRADE AFFAIRS, THE 3M CO., ST PAUL, MN,

Mr. KUMM. Mr. Chairman and members of the Senate Finance Committee, my name is Kenneth Kumm. I am manager of Customs and Trade Affairs for the 3M Co. of St. Paul, MN. I appear here today as chairman of the Joint Industry Group. I am also accompanied by Marjorie Shostak of the American Exporters and Importers Association, who would like also to make a brief statement following my statement.

The Joint Industry Group is a business coalition of U.S. manufacturers who export and import, and trade associations and other firms with an interest in Customs affairs.

As a business coalition, we are very much aware of the economic consequences of the failure of efforts to achieve a meaningful reduction in the Federal deficit. An issue we are concerned with here involves some $500 million in proposed customs user fees, a sizeable amount of money but hardly enough to solve the budgetary deficit.

As this committee is well aware, the customs tariff was the first tax enacted by Congress, and the Customs Service was one of the first Government agencies.

Although trade policy considerations long ago replaced revenue needs as a principal determinant of tariff levels, the assessment and the collection of Customs duties is still the primary responsibility of the U.S. Customs Service.

The Customs Service collects approximately $14 billion in Customs revenues and expends approximately $700 million in collecting the revenue and in performing many other services, including the enforcement against illicit traffic.

These other services have little to do with the services for which the Customs users fee is proposed. The whole proposal was urged upon and accepted by the Budget Committee in the Senate and in the House with no examination of its validity other than as a revenue source.

The Joint Industry Group disagrees with the basic rationale of the proposed Customs user fees, and it opposes its enactment as a bad precedent. Actually, what is proposed are taxes on businesses and individuals conforming with Government rules and regulations issued for the general public benefit.

The so-called services are really normal Customs operations which confer no special benefit on the so-called users.

Our written statement indicates that the users fee proposed would subject the United States to charges of GATT violations.

However, in today's atmosphere, such an argument is of doubtful effectiveness. Nevertheless, the United States has spent decades in an international effort to eliminate such special fees outside of the regular Custom tariff structures. We should not reverse our course with so little examination of the consequences.

As exporters, we must recognize that the same type of fee on incoming traffic and passengers can easily be adopted by other countries; perhaps at a much higher level, to the detriment of U.S. economic and commercial interests.

We strongly urge the committee to reject the Customs users fee proposal at this time. We believe that the full examination will reveal lack of the appropriateness of the concept of users fees on normal Customs operations performed during regular working hours and at reasonable worksites, and which confer no special benefits on businesses and individuals conforming to the Custom Service's own regulations.

And with your permission, I would like to follow that with Marge Shostak's presentation.

The CHAIRMAN. Ms. Shostak, go right ahead.

[Mr. Kumm's written testimony follows:]

TESTIMONY OF KENNETH A. KUMM, CHAIRMAN OF THE JOINT INDUSTRY GROUP

Mr. Chairman, Members, good morning

I am Kenneth A. Kumm, Manager of Customs and Trade Affairs for the 3M Company, and Chairman of the Joint Industry Group. The Group is a coalition of American manufacturers, carriers, retailers, exporters and importers that is broadly representative of all elements of the American business community involved in international trade. Today, the Joint Industry Group is discussing the issue of Customs users fees on behalf of the following Associations and members they represent:

1. Air Transport Association of America — a trade and service organization for the nation's scheduled airlines. The ATA supports and assists member airlines by promoting aviation safety, advocating industry positions, conducting designated industrywide programs and assuring public understanding of the airlines.

2. American Association of Exporters and Importers — an association of over 1,000 importers and exporters involved in international trade, including the service industry.

3. American Electronics Association — has 2,700 member companies covering all elements of the U.S. industrial electronics industry including semiconductors, computers, telecommunications, etc..

4. American Retail Federation — an umbrella group representing the 50 state and 32 national retail associations and through its membership more than one million establishments throughout the nation.

5. Cigar Association of America — the non-profit, national trade organization which represents manufacturers, importers and suppliers of 95% of the large cigars sold in the United States.

6. Computer & Business Equipment Manufacturers Association — a trade association of manufacturers and assemblers of information processing, business communications products, supplies and services. It has 38 members with combined sales of over $110 billion and who employ more than 1.2 million people world-wide.

7. Council of American-Flag Ship Operators (CASO) — represents the majority of the U.S.-Flag liner operators. CASO member companies own and operate approximately 140 large, modern liner vessels in the international commerce of the United States.

8. Electronic Industries Association — with more than 1,000 participating companies, is the full service national trade organization representing the entire spectrum of companies involved in the manufacturing of electronic components, parts, systems, and equipment for communication, industrial, government and consumer end uses.

9. Foreign Trade Association of Southern California — an international business association of almost 500 members that addresses both import and export issues.

10. International Hardwood Products Association — is the U.S. group representing suppliers of tropical forest products. Its membership includes U.S. importers, overseas producers, exporters, and export associations, as well as U.S. ocean carriers, customs brokers and manufacturers. It represents buyers of over 85% of total forest product imports.

11. Motor Vehicle Manufacturers Association — is the trade association for U.S. car, truck, and bus manufacturers. Its ten member companies produce more than 99% of all domestically built motor vehicles.

12. National Association of Manufacturers — the oldest national broad-based trade association with approximately 13,000 members representing over 80% of the U.S. industrial output and employment.

13. National Association of Photographic Manufacturers — a voluntary trade association composed of companies large and small, both domestic and non-domestic. The vast majority of our members engage in exporting and importing photographic products as a substantial portion of their business.

14. National Council on International Trade Documentation — a non-profit privately financed organization, dedicated to simplifying and improving international trade documentation and procedures, including information exchanged by paper or electronic methods.

15. National Customs Brokers & Forwarders Association of America — the national trade association of licensed customs brokers and international freight forwarders in the United States with 29 affiliated local associations at major ports throughout the country.

Since there is no specific legislation now before you for consideration, I propose to discuss Customs users fees in general terms and to draw upon our understanding of past proposals in this area.

Several factors should be carefully considered before preceding with proposals in the Customs users fees area.

1. The Proposed Charges Are Not "Users Fees"

The U.S. Customs Service is a tax collection and law enforcement agency. Its role is analogous to that of the I.R.S. and the F.B.I.; it is hard to see that Customs' work in processing entries is a "service" to the individual tax payer. Rather its functions serve the general welfare and the costs should be borne by the general revenue. Businesses do not use Customs' services, rather they are subject to them.

The JIG does not oppose Customs' current practice of charging businesses for special services, such as when they want Customs activities to be performed outside regular business hours.

The Group does agree with the General Accounting Office's study of the users fees concept in the Customs area, (see paragraph II, page 1280, GAO/OCG-85-1 of 2/15/85):

> "Although additional users fees could be assessed above the current level if special services are provided, GAO does not believe there is merit in assessing users fees for those formalities that are not voluntary because these formalities protect the nation as a whole."

Ambassador Brock expressed a similar view to the United States Trade Representative in a July 14, 1982 letter to the Joint Industry Group:

> "Specifically, we feel that users fees for Customs Services are only appropriate when those services are rendered to clearly identifiable users, rather than in cases where the only identifiable beneficiary is the general public.

> "Moreover, since it is understood that Customs users fees are not broadly applied by other countries, their application by the United States might well result in our trading partners utilizing them to the detriment of our exports."

2. Customs' Duties Exceed Customs' Costs

Some might believe that those with whom a law enforcement or tax collection agency works should specifically pay the cost; by that token every passing motorist should pay 15 cents to the school crossing guard. However, it should be emphasized that the import taxes collected by U.S. Customs already exceed its costs of operation (including non-commercial operations such as narcotics interdiction — which Customs estimates consumes half of its budget) by a factor of almost 20 to 1.

The issue, so far as the Customs Service's budget is concerned, is not whether they pay their way but how the U.S. Government keeps its books.

3. The Proposal is Inconsistent with our Obligations Under the General Agreement on Tariffs and Trade

While Article VIII 1(a) of the GATT provides that fees can be collected that are "limited in amount to the approximate cost of services rendered," this wording needs to be considered in context rather than in a vacuum. For example, the phrase continues "and shall not represent an indirect protection to domestic products." It is hard to see how an increase in the cost of imports equal to a 5% increase in total duties cannot effectively represent increased protection; many battles in the Tokyo Round were fought over much smaller amounts. GATT Article VIII also states that any fees "shall not be for fiscal purposes." However, the purpose of these fees is, rather obviously, fiscal.

Further, GATT Article VIII 1(b) states "The contracting parties recognize the need for reducing the number and diversity of fees and charges referred to in sub-paragraph (a)." Article VIII 2 provides that "A contracting party should, upon request by another contracting party or by the CONTRACTING PARTIES, review the operation of its laws and regulations in the light of the provisions of this Article."

It is clear that GATT's intent was to accept, on a limited basis, certain practices pre-existing at the time it was written in 1947, but with the expectation that these practices be reduced, not expanded.

GATT Article II 1(b) states, in part, that imports "shall also be exempt from all other duties or charges of any kind. . .in excess of those imposed on the date of this Agreement. . . ." While this is modified by Article II 1(c) which permits "fees or other charges commensurate with the cost of services rendered," this provision would require determinations:

a) that Customs' tax collection and regulatory activities are indeed "services rendered," and
b) that the charges are "commensurate with the cost."

Both of these requirements could be difficult to meet.

There is also the likelihood that other countries will consider these fees to be impairments of concessions made under the various tariff negotiation rounds conducted since 1947. This could lead to demands for concessions, dispute settlement actions, etc.

Further, while it is not certain that the United States would be found to be in violation of the GATT, it can be safely assumed that other countries would retaliate in one form or another to the detriment of U.S. exports. In addition, this proposal would signal a lack of commitment to the GATT at the very time the United States is trying to strengthen it.

Canada, Mexico, the United Kingdom, Germany and Japan are certainly among our most important trading partners, and they do not collect such users fees.

4. Inconsistency With Longstanding United States Trade Policy

The United States has been the leader in recent years in securing the elimination of similar charges in several other countries and there are apparently few countries that still use them. It would be anachronistic for the United States to reverse its position, not simply because of the likely direct reaction, but because of the overall trade policy message it would convey. This could be particularly important at a time when the United States is trying to use the GATT Ministerial Meeting this November as the basis for future strengthening of the world trading system and when many other GATT members already have more protectionist views.

5. The Proposal Would Raise Significantly Less New Revenues than the Amount of the Charges

Except in unusual economic circumstances, these fees would not be borne by foreign sellers. Rather, they would either be absorbed by American importers or in turn passed on to American consumers. Where carried by business they would reduce profits (thereby reducing corporate income taxes); where carried by individual consumers, they would reduce purchasing power thereby reducing economic activity and consequently both corporate and individual tax collections. While we have no exact figures, an educated guess puts this loss at about 35% of the anticipated income.

In addition, Customs will face a considerable increase in costs to collect these users fees, especially on entries that are "duty free." Again, exact costs are not available to us, but if it should average $5 per entry, another 5% would be lost. Similar "leakage" would occur with the other fees, such as those on travelers.

6. It is Probably Impossible to Make the Fees Equitable and Non-Discriminatory

If the fees are based upon the average cost of entry processing by Customs, the impact will fall very heavily on low value imports, and could often make these imports prohibitively expensive. On the other hand, if they are based on a sliding scale, larger value/volume imports will bear a disproportionate share of the cost (since entry processing costs are not necessarily related to the size of the entry) which represents a subsidization of small shipments by large ones (however, not necessarily of small business by large ones), which would result in misallocations of resources. If they were based upon complexity this would create other distortions. For example, "Item 807" entries are often complex for Customs to process; this would indicate the need for a high fee, however high charges could discourage use of U.S. origin components in these products. The downstream effect would be to encourage their replacement with foreign made components — which would be entirely counterproductive to the interest of the United States.

The 1982 proposal apparently envisioned that anti-smuggling and narcotics interdiction costs would be included in these "users fees." In effect, the honest travelers and importers — not the general revenue or the smuggler — would pay these costs. This is not only inequitable, but also reemphasizes that these additional taxes are not "users fees."

7. They Would Discourage Customs' Productivity Efforts

The U.S. Customs Service, with its long and honorable traditions, is nevertheless hampered by procedures that reflect its status as the oldest agency in the Executive Branch. It has in recent years been responding very positively to the pressures of budget restraint to modernize its operations. It should be encouraged to maintain these laudable efforts. However, it is hard to see how putting its operations on a "cost plus" basis could do anything but hamper these efforts to strengthen efficiency and productivity. Indeed, if what occurred with bonded warehouses were to be repeated more broadly, we can expect a rapid escalation in these fees over a short period of time. (Indeed unofficial reports suggest that the proposed fees have already increased 50% since the issue was last considered three years ago.)

8. The Congressional and OMB Budget Authorization Process Provide Essential Functions Whose Effectiveness Could Be Impaired

At a time when national resource allocation in terms of the Federal Budget is becoming essential, the procedures used by both the Congress and the Administration to ensure that resources are not wasted are critically important. It is, therefore, necessary that a proposal not be implemented that removes an agency from scrutiny during such procedures.

This issue is also important so far as Customs is concerned from a different perspective. Customs as an agency is increasingly involved in law enforcement, para-military and intelligence operations. Our Nation's history has long ago proven that such activities, necessary as they are, become abusive and counterproductive if not subject to review and control. One of the most important ways on which this is achieved is through control of the purse strings — which could be lost through a poorly-conceived "users fees" system.

9. The Real Solutions

Certainly the Customs Service has inadequate resources to meet its responsibilities and the Group sympathizes with its needs in this direction. As discussed, however, this so-called "users fees" approach appears inappropriate. The Group respectfully suggests that there are alternatives that are much more suitable.

A. Customs is already taking commendable steps to improve its productivity, such as the Automated Brokerage Interface system. However, at times its proposals appear to be developed in a political vacuum and are not effectively implemented because of the reactions, and sometimes overactions, that result. The Group suggests that the existing efforts could be further strengthened by closer work with the private sector to develop approaches that are recognized as mutually beneficial.

B. As Customs has often noted, it enforces about 400 laws for roughly 40 different Federal agencies. However, it does not appear to be adequately re-imbursed for the cost of these services by those who are the real beneficiaries of them. In an economic sense, this should be done. For example, one major responsibility of the Service is gathering statistics on international trade for the Bureau of the Census. It would seem that Census could determine the timeliness and method of collection of these statistics. If the Bureau were charged by Customs for the cost of this effort, Census would have a stronger voice in insuring their accuracy. In this way, the costs would be borne by the real parties at interest — those that want the statistics.

Similar re-imbursements should also be made for the true costs of the work done by Customs for other agencies.

Narcotics interdiction should be funded as a separate and specific line item.

As it has in the past, the Group stands ready to work with Customs on productivity enhancement projects. Indeed it has made specific proposals, such as a Periodic Entry System for handling Customs entry's paperwork in a reasonably modern manner, rather than on the individual shipment basis that has been used for two centuries. Countries such as Germany and the United Kingdom long ago moved to more modern systems.

Thank you very much for providing the Group with the opportunity to express these views to you today. We would be glad to clarify our ideas and suggestions if and when there is a specific legislative proposal that you decide to address; obviously this is an area that should only be acted upon with great care and consideration. I would be most happy to answer any questions that you may have.

STATEMENT OF MARJORIES SHOSTAK, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF EXPORTERS IMPORTERS, LOS ANGELES, CA

Mr. SHOSTAK. Thank you very much for the opportunity to appear.

Mr. Chairman and members of the committee, my name is Marjorie M. Shostak. I am the senior member of the Los Angeles headquartered Customs and International Trade law firm of Stein, Shostak, Shostak & O'Hara. I appear today as a director of the American Association of Exporters Importers [AAEI], and as chairman of its southern California unit. Our association appreciates very much this opportunity to appear and express on behalf of our over 1,000 member firms opposition to the proposal for imposition of Customs users fees.

The proposal to assess fees for the filing of entries is in effect an added tax for the privilege of paying Customs duties required by law, equivalent to requiring the payment of fees to the IRS for complying with the requirements of the law for filing and paying income tax.

It also is discriminatory in that proportionately higher burdens would be imposed on small users. As pointed out in the Grace Commission report of the task force on user charges, such fees are appropriate when collected from recipients of Government goods, services, and other benefits not shared by the general public, and which provide a specific benefit to an identifiable recipient.

In the case of the Customs clearance of imported merchandise and collection of customs duty, it is the obligation of the Customs Service to the public to carry out these functions, including inspection of imported merchandise, and showing the correct amount of duties is deposited, and that quotas are not exceeded, and that all required documents are filed. These are functions required by law to be carried out by the Customs Service for the general welfare as well as to protect domestic industries, and not for the benefit of those who would be required to pay it.

So, we ask that these be taken into consideration by the committee. And I have also been requested by the Los Angeles area Chamber of Commerce and the Foreign Trade Association of Southern California to advise the committee that they share the views expressed by the Joint Industry Group and the AAEI in its written statement, which we ask be included in the record.

The CHAIRMAN. It will be in the record. Thank you.

Mr. Landry.

[Ms. Shostak's written testimony follows:]

Testimony of Marjorie M. Shostak on Behalf of the American Association of Exporters & Importers

Mr. Chairman, members of the Committee. I am Marjorie M. Shostak, senior member in the Los Angeles head-quartered Customs law firm of Stein Shostak Shostak & O'Hara. I appear before you today in my capacity as a Director of the American Association of Exporters and Importers (AAEI), and Chair Person of its Southern California Unit.

The Association's membership of over 1,000 firms are engaged in every aspect of international trade. The products imported and exported by AAEI member companies include chemicals, electronics, textiles and apparel, machinery, footwear, foods, automobiles, and toys. AAEI members also include many companies which serve the international trade community, such as custom house brokers, freight forwarders, banks, attorneys and insurance carriers.

We appreciate the opportunity to present on behalf of AAEI's membership the Association's views in opposition to proposals in the President's Budget for impositions of user fees by the U.S. Customs Service on a broad range of functions.

The U.S. Customs Service is a tax collection agency. Its functions also include regulation of trade. In its collection capacity, its role is analagous to the role of the Internal Revenue Service in collecting income taxes. To impose a "use fee" for the privilege of paying the customs duties required to be deposited as a condition of entry of imported merchandise is analagous to charging a taxpayer a fee for compliance with the laws requiring the filing of income tax returns and the payment of income taxes.

The customs clearance of imported merchandise, inspection of merchandise, assessment of duty, and determination that the goods are not prohibited from importation by law or regulation, is not a "service" to the importer/taxpayer. It is an obligation of the Customs Service to the public to carry out these functions and to insure that the correct amounts of customs duty are deposited, and that no laws are violated by the importations. These functions are no more a "service" to the importer than is the processing of an income tax return and the collection of the income tax payable. In each case, the function is a requirement of the law, carried out by a government agency for the general welfare. As such, the cost of this operation should be borne by the general revenue and not by the taxpayer. In each case, it is not a desired service, but a requirement from which the taxpayer receives no benefit.

The fees are said to be designed to recover the Customs Service cost of collection and services. It should be emphasized, however, that the Customs duties collected by the U.S. Customs Service far exceed the costs of its collection/inspection functions by a ratio of 20 to 1.

Implementation by the United States of a system of imposing fees for all or most of its functions, would be perceived by our trading partners as an increase in duties, fees and assessments and a move toward greater protectionism. Our members are concerned that other countries would retaliate by imposing similar fees on U.S. exports. It is also a matter of concern that the proposed user fee charges are incompatible with the rules of the General Agreement on Tariffs and Trade, which requires that fees in connection with imports "shall be limited in amount to the approximate cost of services rendered and shall not represent an indirect protection to domestic products or a taxation of imports or exports for fiscal purposes."

Further, the proposal to impose user fees on imports is not consistent with the objective of Article VIII(b) of the GATT, that the contracting parties recognize the need for reducing the number and diversity of fees and charges. In addition, imposition of fees will add to the cost of imports, and would be inflationary. Such fees would not raise net revenues significantly, because the payment of fees on imports would constitute a deductible business expense which would reduce profits and result in lower taxes on net earned income.

The imposition of such user fees was not recommended by the President's Private Sector Survey on Cost Control. In the Report of the Task Force on User Charges, the Grace Commission pointed out (at page 196) that Customs passenger processing and requirements for the formal and informal entry of merchandise are for the benefit of society as a whole. These functions protect the revenue, deter smuggling and the importation of contraband, and are necessary to enforce the laws. As further stated therin, the formal and informal entry of goods and entry by mail are services that support the general economy and for which a fee -- the duty on goods or postage -- has already been paid. In addition, these functions are carried out as a protection for domestic industry.

For all of the foregoing reasons, we wish to register the objection of our nationwide membership to the concept of imposing user fees on the functions of a revenue producing agency, and urge that these proposals be rejected.

STATEMENT OF JAMES LANDRY, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, AIR TRANSPORT ASSOCIATION, WASHINGTON, DC

Mr. **LANDRY**. Thank you, Mr. Chairman.

My name is James E. Landry. I am senior vice president and general counsel for the Air Transport Association of America, which represents most of the scheduled airlines of the United States. Seventeen of our member airlines provide regularly scheduled air service between the United States and more than 70 countries.

In light of the time constraints, I will confine my comments to three basic questions, which we urge the committee to consider in weighing the proposals for so-called user fees for the inspections performed by the Customs Service.

The questions and, in our view, the answers are the same whether you are considering the bill which has been proposed in the name of deficit reduction or the administration bill espoused by the Deputy Commissioner of Customs in his appearance here this morning.

First, should user fees be imposed for services that primarily benefit the public at large? We think, as the GAO concluded earlier this year and as indeed the President stated in his 1983 budget message, that the answer is a resounding No.

Second, should user fees be assessed for services which the user is compelled by statute to use? Again, as would be the case if the Internal Revenue Service imposed a fee on a citizen for filing his income tax return, we believe that the answer has to be "No."

And third, should user fees be assessed which are in violation of, or inconsistent with treaties or other international agreements, and which will prompt costly retaliatory actions by governments around the world? As the prospective targets of those retaliatory actions, we firmly believe the answer is "No."

In short, the proposed so-called users fees, which are in reality a tax, pure and simple, fail on all three of the critical counts I have outlined. We urge this committee to reach the same conclusion.

We believe that, working with you and the Customs Service, we can find alternative approaches to accomplishing the missions of the Federal inspection services without further burdening the budget.

Thank you, Mr. Chairman.

The CHAIRMAN. I have no difficulty understanding your position. [Laughter.]

Mr. St. John.

[Mr. Landry's written testimony follows:]

STATEMENT

OF

JAMES E. LANDRY

SENIOR VICE PRESIDENT AND GENERAL COUNSEL

THE AIR TRANSPORT ASSOCIATION OF AMERICA

My name is James E. Landry. I am Senior Vice President and General Counsel for the Air Transport Association of America, which represents most of the scheduled airlines of the United States. Seventeen of our member airlines provide regularly scheduled air service between the United States and more than 70 countries.

We appreciate the opportunity to testify on the general user fee concept in the context of these hearings on deficit reduction. We hope we will be permitted to present our views on specific user fee bills when they are before the Committee, but prior to mark up. Today, we will comment on the issues raised by the imposition of user fees as a general concept and also with immediate specificity to the proposal that such fees be imposed by the U.S. Customs Service.

We believe that user fees are singularly inappropriate for application to federal inspection agencies, such as the U.S. Customs Service. However, we are also concerned about budgetary constraints placed on the Customs Service as reflected in the Administration's current and past budgets. Today, the airlines pay the bill for the operation, maintenance and rentals of United States Customs facilities at airports, as well as other aspects of the inspection process, such as inspector overtime. Indeed, at the several preclearance locations in Canada, Bermuda and the Bahamas, the airlines also pay for the customs inspectors' housing, duty-post and educational allowances, plus home leave and associated transportation costs, together with equipment, supplies and administrative costs, and the costs of supervising the preclearance installation. The total annual cost of these airline expenditures for the conduct of the U.S. Customs mission at airport locations at home and abroad is approximately $67 million.

Our concern for Customs' budgeting constraints, however, does not lead us to conclude that user fees are either a necessary or proper solution. There are other better, more cost effective, and more equitable ways to address the problem of Customs resource adequacy. We are prepared to work with the Committee to explore alternative ways to assure the adequacy of federal inspection services without further burdening the budget.

I. THE ISSUES RAISED BY THE GENERAL CONCEPT OF USER FEES FOR GOVERNMENTAL SERVICES

The airline industry endorses the view, stated by the President, that: "In cases where the general public is the recipient of the benefits of a Federal program, rather than a clearly identified group, users fees will not be imposed."[1]

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[1] See statement from the President's FY 1983 Budget Message.

Or, as stated more recently, in a February 1985 report with specific regard to the U.S. Customs Service: "GAO does not believe there is merit in assessing user fees for the formalities that are not voluntary because these formalities protect the nation as a whole."[2/]

From the airline industry perspective, there are three fundamental questions which warrant extensive inquiry with respect to Administration user fee initiatives recommended by the First Concurrent Resolution on the Budget for FY 1986:

- What will be the standard for determining whether a particular government service should be paid for by the imposition of a user fee;
- What role is the payor of the user fee to have in determining how, when, and where the service is performed; and
- How will the fee be calculated and collected?

I would like to make several observations with respect to these questions, and suggest a possible approach for answering them.

[2/] Comptroller General, Compendium of GAO's Views of the Cost Saving Proposals of the Grace Commission, GAO/OGC 85-1, February 19, 1985.

A. The Standard for Determining Whether a User Fee Is Proper

User fees should not be code words for double taxation. Through taxes, all U.S. citizens have already paid for services provided by our government. They should not be forced to pay once again for the same services, unless they receive special benefits above and beyond those accruing to the public at large. Another way of saying this, as concluded by the General Accounting Office, is that no user fee should be assessed for a service that primarily benefits the general public. For example, a taxpayer should not have to pay the Internal Revenue Service for processing his or her tax return, nor should a traveler entering or returning to the United States have to pay a U.S. Customs official for collecting duties owed by the traveler.

It is also inappropriate for a person, or an airline, to pay for a service it is compelled by statute to accept. For example, public interest benefits derive from the statutory requirements which force airlines and others to undergo a government inspection service. These occasions are not proper for the imposition of user fees. It follows then, a fee should not be charged when the government service primarily benefits the public at large, or when the service performed is a result of a statutory obligation.

A third instance when a charge should not be assessed involves foreign relations. Thus, a fee should not be charged when to do so would be inconsistent with international treaties or agreements, or when it would be likely to result in retaliatory action by a foreign government. In this regard, a standard clause in most U.S. bilateral aviation agreements stipulates that neither country will assess air carriers "inspection fees [or] any other charge or tax" in connection with the provision of agreed-upon air transport services. Similarly, Article 24 of the International Convention on Civil Aviation (Chicago, 1944) requires that contracting parties admit "[a]ircraft on a flight to, from or across the territory of another contracting State" temporarily free of duty. As a treaty to which the United States is a party, the "Chicago Convention" is, of course, the law of the land. Several years ago, despite these provisions, the U.S. Customs Service proposed to exact user fees on arriving aircraft, until protests by the State Department and many foreign governments gave Customs cause for reconsideration. Wisely, Customs subsequently withdrew its proposal for, as the State Department noted, the imposition of user fees for services involving international air transportation could cause significant adverse consequences. The Deputy Assistant Secretary of State said, in this connection, that user fees can:

> "set a precedent which would undoubtedly be followed by many other countries. Some of these nations could apply such charges to imports as well as aircraft. These charges could be used as a trade barrier. The potential inconvenience and cost to U.S. citizens, exporters and air carriers . . . would indeed be high."[3]

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[3] See attached July 23, 1982 Department of State Letter.

To summarize, any standard for determining the appropriateness of a user fee must be consistent with our international obligations, and should not invite retaliation.

B. The Role of the Payor

When persons and industries are properly required to pay for a service, they should have a voice in how, when, and where that government service is to be provided. The cry of "no taxation without representation" is as valid today as when first uttered. When a government agency has a monopoly on the service provided, Congress is obliged to establish some form of countervailing input by the consumer of a mandatory government service.

To do this, Congress should then require the agency to establish a formal advisory committee under the provisions of the Federal Advisory Committee Act. Such an advisory committee would make appropriate recommendations on the how, when, and where of user fee charges and the agency should be required to give substantial deference to the recommendations of this committee.

In any event, if Customs "user fees" are mandated notwithstanding their inappropriateness, the Customs Service must be urged to process incoming passengers and cargo in an expeditious manner. Any such legislative language should specifically reflect that a reasonable standard to strive for in the processing of passengers on arriving flights is an average of 45 minutes. A similarly appropriate standard should be established for the processing of incoming cargo.

C. The Calculation and Collection of the Fee

Congress should set up standards for the calculation and collection of a user fee, requiring the government agency concerned to make a full public disclosure of how those standards are applied. Under no circumstances should an additional fee be assessed to cover the administrative costs of collecting the basic fee. That is, no general administrative or overhead charges should be added to a user charge fee. In fact, consideration should be given to providing for "volume discounts" and other incentives in return for efficient ordering of services by users. When and where appropriate, a government agency should be permitted to contract out services which can be provided more efficiently by a private party. This is what the U.S. Public Health Service does today when medical service is needed at airports of entry. Finally, the collection of the user fee must not be done in such a fashion as to impede or delay the inspection process itself.

D. Existing Fees

All existing user fees should be sunset after a two-year transition period, so that fees under the new standard can be implemented. Unlike current user fees which are deposited in the Treasury General Fund, new fees should be remitted directly to the agency imposing the fees so that services provided can be performed on a self-sustaining basis.

E. Congressional Oversight

Although the Supreme Court has invalidated the legislative veto approach to Congressional oversight of government agency activities, the Court is not adverse to statutes requiring agencies to delay implementation of regulations for a reasonable period of time during which Congress can consider remedial legislation. Imposition of a widespread system of user fees would result in a radical change in the traditional ways of conducting business. Therefore, it would behoove Congress to require a government agency to delay implementation of any new user fee regulations for a minimum period of six months after tendering the regulations to appropriate Congressional oversight committees.

II. THE PROPOSAL FOR CUSTOMS SERVICE USER FEES

As noted before, the Air Transport Association strongly opposes the concept of user fees in connection with services provided by the several United States inspection agencies, namely, the U.S. Customs Service, Immigration and Naturalization Service, Animal and Plant Health Inspection Service and the Public Health Service. In our view, the U.S. Customs Service, which brings in over $20 in revenue for each dollar it spends, represents the most egregious example of the inappropriateness of such fees. Aside from the fact that the Customs Service is the second greatest revenue-generating agency of our government, its services are solely designed to benefit and protect the general public and national welfare.

Should a victim pay a user fee when a policeman catches a purse-snatcher? Should a taxpayer reimburse the Internal Revenue Service for processing a tax return? Surely the answer is no in both cases and the answer also should be no in the case of Customs' mandatory inspection services.

The airlines fully recognize, as good corporate citizens, the need for services for the public good by the inspection agencies, even though such services are by definition an impediment to the free conduct of airline operations. But, that is why citizens pay taxes, and why "user fees" are by definition inappropriate when services rendered are for the benefit of the general public.

The services provided by the federal inspection agencies are designed to achieve Congressionally mandated public policy goals such as preventing entry of illegal drugs and other products, inadmissible aliens, or prohibited plants and animals; enforcing tariffs to protect American labor from destructive competition and discrimination; and collecting duties and taxes on imported merchandise.

The airlines do not derive any special benefit from these services. The services were not instituted at the request of the airlines. They were not developed to enrich or promote the airline industry. In a more perfect world, such services would not be required at all, and the airlines could engage freely in the business of air transportation without having to cope with the impediments and delays caused by the inspection process. In our view, these are precisely the kind of services which benefit primarily the general public, which the President has said will not be the subject of user fees.

The Customs Service fees proposed by the First Concurrent Resolution on the Budget for FY 1986 contravene the obligations assumed by the United States under the General Agreement for Tariffs and Trade (GATT). The United States is committed under GATT to limit fees in connection with imports and exports "to the approximate cost of the services rendered" and to refrain from utilizing such fees for "fiscal purposes" and from increasing "the number and diversity of fees". As previously emphasized by the Department of State in its letter attached to this statement, user fees also would be inconsistent with the Chicago Convention, the cornerstone treaty underlying all international civil aviation operations.

User fees also are in contravention of the provisions of Annex 9 to the Chicago Convention on International Aviation. An obligatory International Standard therein (par. 6. 55) provides that "[C]ontracting states shall provide sufficient services of the public authorities concerned without charge to operators during working hours by those authorities" (Emphasis added). The United States was the driving force behind the creation of the International Civil Aviation Organization (ICAO) in 1944, and is a preeminent supporter of that body today -- as reflected by its on-going assessment of 25 percent of the budget -- and must notify ICAO of any differences from its International Standards, such as the one just cited.[4] As the result of any user fee legislation, the United States would be required to file a difference with ICAO. One can be sure that prompt, widespread and costly retaliatory action would result.

III. ALTERNATIVE APPROACHES TO ASSURE THE ADEQUACY OF FEDERAL INSPECTION SERVICES FOR INTERNATIONAL AIR TRAFFIC

As we noted previously, the airlines are acutely aware of the budgetary constraints under which the Customs Service has consistently labored over the past years. Such constraints have been imposed notwithstanding Customs' annual revenue collections of over $13 billion, and its administration and enforcement of some 400 laws of over 40 other federal agencies. Its often inadequate inspector staffing at our gateway airports strains to cope with the congestion created by the ever-growing stream of international air travelers and goods. Over the years, we have joined with others in the private sector in urging realistic Customs Service funding by the Appropriations and Authorization Committees of the Congress.

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[4] Article 38 of the Chicago Convention reads as follows: "Any State which finds it impracticable to comply in all respects with any such international standard or procedure, or to bring its own regulations or practices into full accord with any international standard or procedure after amendment of the latter, or which deems it necessary to adopt regulations or practices differing in any particular respect from those established by an international standard, shall give immediate notification to the International Civil Aviation Organization of the differences between its own practice and that established by the international standard...."

However, we recognize that the U.S. deficit requires U.S. spending cuts from which the Customs Service cannot be excepted. Therefore, we have assembled a team of air industry experts from the facilitation, legal, cargo and government affairs fields, with a high priority task of exploring and recommending alternative approaches to accomplish the missions of the federal inspection services without further burdening the budget. We ask this Committee and the Congress to allow us to work with you and the U.S. Customs Service to this end. The U.S. Customs Service user fee proposal must be rejected. It is an inappropriate measure which will only result in costly retaliatory measures by other countries. There are other ways to solve the problem. Working together, we will find them.

Attachment

DEPARTMENT OF STATE
Washington, D.C. 20520

July 23, 1982

The Honorable
William von Raab,
Commissioner of Customs,
U.S. Customs Service.

Dear Mr. Commissioner:

The Department of State submits herewith its comments on the Customs notice of proposed regulation amendment. This proposed amendment would establish a schedule of fees which Customs would charge for the clearance of aircraft engaged in international commerce. The level of fees would be based on the cost to the Customs Service of performing this function.

After careful review, the Department has concluded that such fees would be inconsistent with international treaties and bilateral aviation agreements to which the United States is a party. Furthermore, implementation of this proposal would encourage other nations to impose such charges on U.S. international airlines.

Article 24 of the International Convention on Civil Aviation (Chicago, 1944) requires that contracting parties admit aircraft engaged in international flights temporarily free of duty. In addition, this article exempts fuel, lubricating oils, spare parts, regular equipment and aircraft stores on board such an aircraft from customs duty, inspection fees or similar national or local duties and charges. The purpose of this article is to assure that aircraft engaged in international flights would not be subject to import duties or customs fees in individual countries. The fees proposed would not be consistent with this exemption principle.

Bilateral aviation agreements between the United States and foreign countries contain provisions exempting aircraft of the parties from customs inspection fees. Although the language of these provisions varies, the intent is the same. For example, Article 8 of the U.S. Air Services Agreement with Italy stipulates that: "Aircraft of carriers designated by either Contracting Party, which are engaged in air transport services provided for in the present agreement, shall be permitted to enter and depart from the territories of the other Contracting Party without payment of customs duties, inspection fees and any other charge or tax."

Other air transport agreements, such as that between the United States and Thailand, require that aircraft be exempt from fees and charges on a reciprocal basis. Thus, should the United States impose such fees, these countries would almost certainly do so.

A substantial number of our aviation agreements require that airlines of the other nation be accorded treatment no less favorable than that accorded national carriers or those of the "most favored nation." Thus, if any nation is exempted from these fees, these nations would be exempt.

Finally, there are numerous aviation agreements requiring that the nations involved accord one another "national treatment." If for any reason U.S. carriers were exempted from the customs fees, carriers of these nations would also be exempt.

Clearly, the customs fees proposed would be inconsistent with U.S. obligations under many of our bilateral aviation agreements. Moreover, exempting the foreign airlines affected would mean discrimination against those airlines, U.S. or foreign, which were not exempt. Whichever horn of this dilemma were chosen, the result would be to spend limited U.S. resources in acrimonious consultations and even costly arbitration with our aviation partners. The governments of Canada and the Federal Republic of Germany have already filed written objections to the proposed amendment.

In addition, the proposed customs fees do not appear to be consistent with U.S. obligations under the U.S.-Canada Agreement on Preclearance. Article VII(b) of this agreement states that "the inspecting party shall be responsible for the normal cost of its inspection personnel." The Customs fee proposal would, in effect, shift the cost of U.S. customs preclearing aircraft in Canada from the United States (as the inspecting party) to the air carrier participants in preclearance.

There remains the problem of precedent and retaliation. At present, very few nations in the world impose any form of customs fees. Nations with such charges usually apply them only to dutiable imports. Airlines are not charged such fees in any major nation. The United States, by initiating the proposed custom fee policy, would set a precedent which would undoubtedly be followed by many other countries. Some of these nations could apply such charges to imports as well as aircraft. These charges could be used as a trade barrier. The potential inconvenience and cost to U.S. citizens, exporters and air carriers of the implementation of this notice would indeed be high.

In contrast, the U.S. has been working over the last several years to convince others of the need to establish an international framework which liberalizes trade in services. The imposition of the fees proposed here would run counter to that major trade policy initiative, which has broad support in the Executive and Legislative branches of the United States Government.

Therefore, for the reasons set forth above, the Department of State believes that Customs should not implement the proposed regulations on customs fees.

Sincerely,

Matthew V. Scocozza
Deputy Assistant Secretary for
Transportation and Telecommunications

STATEMENT OF WILLIAM ST. JOHN, PRESIDENT, NATIONAL CUSTOMS BROKERS & FORWARDERS ASSOCIATION OF AMERICA, NEW ORLEANS, LA

Mr. St. John. Mr. Chairman, thank you for the opportunity to testify before your committee today.

I appear today as president of the National Customs Brokers & Forwarders Association of America. We represent approximately 30 regional organizations around the country that represent brokers.

We customs brokers provide the interface between the U.S. Customs Service and the importing community in the collection of data, preparation of documents, meeting the laws, and collecting the duties that are paid over to the Customs.

We have grave reservations about the user-fee scheme promoted by OMB and Customs and must state our unequivocal opposition to the Customs user fees. Calling these charges user fees is a misnomer that is deceptive, and it needs correction.

User fees were conceived as charges for special government services, voluntarily requested, and resulting in a particular benefit to an entity. Certainly, the filing of documentation and payment of duty in order to meet law requirements is in no sense voluntary, nor does it result in a benefit specifically to the importer. Such service is beneficial to the U.S. population, in that it results in the generation of revenues.

Customs framed its request around the funding for competent, efficient enforcement of the law—something the public should expect without forcing a small segment of the trade community to pay extra for.

The so-called user fee is simply a tax. OMB and Customs have offered this charge for one purpose alone, to raise revenues. This is envisioned by its designers as an opportunity to make a contribution to deficit reduction. Why isn't the user fee called a duty or called a tax? First, the administration is committed to no new taxation, and the semantics of user fee avoids that conflict.

Second, as a tax it would violate GATT.

And, this tax in inflationary, in that the user fee adds to the final cost of the product. As part of costs, this tax receives its share of markup for overhead and profit throughout the pipeline to the consumer. Thus, the public will not only pay for the direct cost of Customs but also will be paying for the added markup caused by the assessment.

The burden of this tax is inequitable. While the tax is posed as a means of underwriting the actual cost of operating the Customs Service, there is no relationship between these fees and actual cost of service. For example, the border ports' processing has significantly lower costs than the processing at seaports.

However, under the scenario offered by Custom user fees would be equal in each case.

Finally, the tax discriminates against small business which, limited by capital, will have smaller quantities in their importation. Firms better capitalized, on the other hand, can change their distribution in transport in such a way as to minimize the assessment. In-bond shipments, which have appreciably lower demand on Customs, are taxed more than their fair share under the Customs proposed-fee schedule, and this of course is at the expense of inland ports and the commerce of these cities.

Furthermore, it results in product discrimination. For example, raw products or products imported in large quantities for transaction, such as vessel loads of oil, will be assessed on the same basis as a container load of nails or possibly a pallet of chemicals. The inconsistencies continue, and we conclude that it is probably impossible to make the fees equitable and nondiscriminatory.

We therefore urge the committee to reject the idea of users fees on Customs activity.

Thank you.

The **Chairman**. Thank you.

Mr. O'Connor.

[Mr. St. John's written testimony follows:]

STATEMENT BY

WILLIAM ST. JOHN, JR.

NATIONAL CUSTOMS BROKERS & FORWARDERS ASSOCIATION OF AMERICA, INC.

Mr. Chairman: Thank you for the opportunity to testify before your committee. I appear today as President of the NCBFAA, a nationwide organization of licensed Customs Brokers and Freight Forwarders, including 29 affiliated regional associations.

Customs brokers provide the interface between the importing community and the Customs Service, establishing the necessary supporting documentation, ensuring that all necessary federal laws are observed, collecting duties in the correct amounts from the importers and then passing these funds to the Customs authorities. It is clear that customs brokers will have a fundamental and substantial part in the implementation of any Customs Service user fee scheme enacted by the Congress. We have grave reservations about the user fee scheme being promoted by OMB and Customs and must state our unequivocal opposition to Customs user fees at this time.

First, these charges are being packaged to the public and the Congress as "user fees", a misnomer that is deceptive and bears correction. User fees were conceived as charges for special government services voluntarily requested and resulting in a particular benefit flowing to an entity. The filing of documentation and payment of duties is not in any sense voluntary nor does it result in a benefit to the importer. It is a service that inures to the general welfare of the balance of the population of the United States - the generation of revenues. It is the public benefitting from the Customs Service that generally pays for revenue collection and that is why funding for Customs has always come through general revenues. For Customs to seek these fees is comparable to the I.R.S. levying a fee on each individual taxpayer for the privilege of filing his income tax form every year. This is not to say that there may not be special circumstances where Customs may provide extra service to suit the convenience of an importer and should therefore appropriately seek compensation. Here, however, Customs has framed its request around funding for competent, efficient enforcement of the law - something the public should expect, not force a small segment of the trading community to pay extra for.

Indeed, this is not a "user fee". It is, quite simply, a tax. OMB and Customs have offered this charge for one purpose alone: to raise revenues. Faced with a massive budget deficit, its architects see an opportunity to make a contribution to deficit reduction. But why not admit it? Why not call it a duty or a tax? First, the Administration has foresworn any tax increase and the semantics of "user fee" avoid that conflict. And, second, if it were admitted to be a tax, it would most assuredly run afoul of the GATT. In today's testimony, the Joint Industry Group, to which NCBFAA belongs, will comment more fully on our view that this proposal would violate the GATT in any event. Suffice it to say that: "A rose by any other name is still a rose." This is a tax.

Underlying this proposal too is the suggestion that Customs duties do not pay for themselves and that therefore there is an extraordinary need to supplement our duty revenues to help pay for those costs. In May, the House Subcommittee on Trade heard Customs discuss the question of additional staffing and admit that there is a 20 to 1 return for every dollar that is spent in this area. That is, for each dollar spent on a Customs agent, clerk or import specialist, the Treasury sees a $20 return through duty collections. To suggest now that a special tax (or "user fee") must be charged to justify the cost of collecting duties is contrary to the facts and to their statements on the record to Congress.

For a moment, however, let us take a look at the impact of these so-called user fees. They will not fall on the backs of the foreign nations or manufacturers. The burden will be borne fully by importers, brokers and ultimately the consuming public. The assessment of this tax is in fact inflationary in that the fees will add to the final cost of the product. As part of the cost, this tax will receive the markup for overhead and profit not only by the importer, but throughout the pipeline to the consumer. So the public will not only pay for the direct cost of Customs, but also the added markup caused by the assessment.

And, the burden will be inequitable. While this tax is posed as a means of underwriting the actual costs of operating customs services, there is no relationship between these fees and the actual cost of service. The cost of Customs processing at border states is significantly lower than at seaports. (Broker fees reflect that and are currently almost 1/4 that at the seaports.) User fees would be equal however under the scenario offered by Customs. The tax is discriminatory against small businesses which, limited by capital, out of necessity have smaller quantities in their importation. Firms better capitalized, on the other hand, can change their distribution and transport in such a way as to minimize this assessment. In-bond shipments, which have appreciably lower demands on Customs, are taxed more than their share under Customs' proposed fee schedule, at the expense of the inland ports and the commerce of those cities. Additionally, it results in product discrimination: raw products or products imported in large quantities, per transaction, such as vessel loads of oil, will be assessed on the same basis as a container load of nails or possibly a pallet of chemicals. The inconsistencies continue and we are led to the same conclusion as the Joint Industry Group: it is probably impossible to make the fees equitable and non-discriminatory.

In July, the House Ways and Means Committee reported legislation that levies a "processing" fee on vessels, based on passenger volume. The committee passed this legislation largely in response to the Budget Committee revenue requirements and have produced potential revenues in the neighborhood of $200 million. NCBFAA has the following position on that legislation: First, we are still opposed to a new Customs tax of any kind. Whether it is termed a "user fee" or a "processing charge", it is none-theless creating a new tax on a limited segment of the population, when the cost of Customs enforcement is of benefit to the entire population of the United States. Second, NCBFAA was relieved, however, that the House Committee recognized the inequity, lack of enforceability and questionable legality of a fee on commercial cargo by striking that concept from their bill. Third, we also believe the House used particular foresight in precluding Customs from unilaterally raising fees (as they have done in other instances) by codifying the amount of the fee in the statutory language. And, finally, we are disturbed that the House version is an unabashed revenue producer and ignores the Customs rationale for these fees in the first place -- to supplement taxpayer funding of Customs services. Some effort should be made to link this fee to improving operations at Customs. The House bill did, however, recognize the revenue value of adequate Customs staffing in the commercial sector by mandating an additional 800 persons to this area in FY 86. NCBFAA supports this provision and again points to Customs own position before the Congress that additional personnel produce more revenue.

It is NCBFAA's view that Customs can realize its objectives much better through greater attention to making its operations more efficient than by trying to establish a new tax which offers a barrier to trade, burdens the consuming public, and discriminates against particular economic and geographic sectors. The Customs Service has embarked in just such a direction in its initiative for automation. Tremendous sums have been invested by government and the private sector to advance this effort. More needs to be done to expedite Customs' conversion to a more modern system of operations - not only through machines but through manpower and management attention. NCBFAA works closely with Customs on a day-to-day basis in its efforts to automate and shares this sense for tomorrow. Our future and Customs' are intertwined: streamlining Customs is to our mutual advantage. Bearing this in mind, please understand our concern about the Customs proposal and its contradictions. At best, this proposal is ill-advised and we hope that the Committee will reject it.

Mr. Chairman, on behalf of NCBFAA, thank you for your time. We would be pleased to respond to your questions.

STATEMENT OF JOSEPH O'CONNOR, PRESIDENT, NATIONAL ASSOCIATION OF FOREIGN TRADE ZONES, WASHINGTON, DC

Mr. O'CONNOR. Good morning, Mr. Chairman and members of the committee. I am Joseph F. O'Connor, president of the National Association of Foreign Trade Zones and director of operations of the New Jersey Foreign Trade Zone. I am accompanied this morning by Bob Chancellor, the executive director of our association as well as Louis Liebowitz, who is the cochair of our Government and Regulations Committee.

My purpose today is to express the opposition of our national association to the imposition of user fees by the U.S. Customs Service to recover the cost of Customs operations.

Our association is a trade association representing most all United States Foreign Trade Zones. Its 250 members represent every aspect of the zone movement—zone management, including zone operators, some companies using U.S. foreign trade zones, grantees, such political entities as cities, counties, and port authorities who operate and grant foreign trade zones.

The normal activities of the U.S. Customs Service are for the benefit of the general public and not a specific business entity. However, in foreign trade zones, Customs is presently reimbursed for 137 percent of its officers' salaries for functions such as inspections, clearance of shipments, and performance of other control activities. These services were authorized by Federal statute in 1934 as reimbursable expenses and are presently being paid for by zone operators or companies using the services.

Some zones have volunteered for a test program, which is now proposed, under new Customs regulations, that imposes substantial fees for activation, operation, modification of zones. These fees already reimburse Customs for all expenses of initial application reviews, premises surveys, and background investigations, merchandise examinations, spot checks, inspections, audits, and clerical support, including management and supervisory expenses.

The levy of a user fee under these circumstances could very well be viewed as an increase in the tariff on merchandise, since reimbursement for services is already being provided. This is likely a violation of the General Agreement on Tariffs and Trade, and it could be a source of retaliation by our trading partners. And this was recognized as such by the U.S. Trade Representative Brock when a similar proposal was made in 1982.

Since Customs already assesses fees on foreign trade zone transactions, this additional fee, in our opinion, does violate GATT.

In addition, the impact of increased costs for Customs user fees would fall most heavily on small businesses, which comprise approximately 50 percent of the users of the U.S. Foreign Trade Zone Program. These companies, because of their limited volume, could ill afford the opportunity to minimize user fees by consolidation of shipments.

While the President's private sector survey on cost control recommended user fees for discrete and clearly identifiable beneficiaries of the Customs Service, these criterias are not met with respect to additional user fees for foreign trade zone entities.

Zones serve as an instrument of international commerce to benefit the consuming public.

Also, in 1982, in a similar user-fee proposal made, a survey of our members indicated the cost of operations would be increased in excess of $13 million. Due to the growth of the zone program, we estimate that current impact could reach the range of $25 million.

In summary, the National Association of Foreign Trade Zones is opposed to Customs user fees because: One, we are already reimbursing Customs for services provided to the tune of 137 percent; and two, small businesses using foreign trade zones would be especially impacted by this increase in costs.

Customs services provided to FTZ's benefit the general public and do not benefit any particular individual or entity. The user fee proposal is likely to violate GATT. And it is estimated that this user fee would increase zone operational costs by $25 million.

I would like to thank you on behalf of our association for the opportunity to present this statement, and I would be pleased to answer any questions you might have.

The CHAIRMAN. Thank you.

Mr. Gross.

[Mr. O'Connor's written testimony follows:]

TESTIMONY BY JOSEPH F. O'CONNOR, ON BEHALF OF THE NATIONAL ASSOCIATION OF FOREIGN TRADE ZONES

Good morning, Mr. Chairman and members of the Committee. I am Joseph F. O'Connor, President of the National Association of Foreign-Trade Zones and Director of Operations for the New Jersey Foreign Trade Zone in Flanders, New Jersey. I am accompanied by Robert T. Chancler, Executive Director of the Association and Lewis Leibowitz, Co-Chairman of our Government and Regulations Committee.

My purpose today is to express the opposition of the Association for imposition of user fees by the U.S. Customs Service to recover the cost of Customs operations.

The NAFTZ is a trade association representing most all U.S. Foreign-Trade Zones. Its 250 members represent every aspect of zone management including zone operators, companies using foreign trade zones, cities, counties and port authorities who are often zone grantees and operators.

The normal activities of the U.S. Customs Service are for the benefit of the general public and not a specific individual or business entity. However, in foreign-trade zones Customs is presently reimbursed for 137% of officers' salaries for functions such as inspection, clearance of shipments and performance of other control activities. These services were authorized by Federal Statute in 1934 as reimburseable expenses and are presently paid for by the zone operator or company receiving the services. Some zones have volunteered for a test program which is now proposed as a new Customs Regulation that imposes substantial fees for activation, modification, and operation of zones. These fees reimburse Customs for all expenses of initial application review, premises survey, background inspections, merchandise examination, spot check inspections, audits, clerical support, and management and supervision expense.

The levy of a "user fee" under these circumstances could very well be viewed as an increase in the tariff on merchandise, since reimbursement for services is already being provided. This is likely a violation of the General Agreement on Tariff and Trade (GATT) and could be source of retaliation by our trading partners and was recognized as such by U.S. Trade Representative Brock when a similar proposal was made in 1982 (See Exhibit A).

In addition, the impact of increased costs for Customs User Fees would fall most heavily on small businesses which comprise approximately 50% of the firms using FTZs. These companies, because of their limited volume, could ill afford to consolidate shipments to minimize user fee assessments.

While the President's Private Sector Survey on Cost Control (Grace Commission) recommended User Fees for "discrete" and "clearly identifiable" beneficiaries of Customs Services, these criteria are not met with respect to additional user fees for foreign trade zone entities. Zones serve as an instrument of international commerce to the benefit of the consuming public.

Also, in 1982, when a similar "User Fee" proposal was made, a survey of our members indicated increased costs of operation in excess of $13 million. Due to the growth of the zone program, we estimate the current impact of increased costs to be in the range of $25 million.

In summary, the National Association of Foreign-Trade Zones is opposed to Customs User Fees because:

- o Customs is already reimbursed for services provided to foreign-trade zones at 137% of Customs personnel expense.
- o Small businesses, who use FTZs would be especially and unfairly impacted by increased costs.
- o Customs services provided to FTZs benefit the general public, and do not benefit any particular individual or entity.
- o The "User Fee" proposal is likely a violation of the GATT.
- o It is estimated user fees would increase zone operational costs by $25 million.

Thank you for the opportunity to present this statement and I will be pleased to answer any questions the Committee may have.

STATEMENT OF LAWRENCE GROSS, PRESIDENT, VAN BRUNT WAREHOUSES, INC., PORT NEWARK, NJ; ON BEHALF OF THE NATIONAL BONDED WAREHOUSE ASSOCIATION, MIAMI, FL

Mr. GROSS. Mr. Chairman, my name is Lawrence Gross. I am the president of Van Brunt Port Jersey Warehouse, which operates bonded warehouses in the New York/New Jersey area.

Today I am speaking on behalf of the National Bonded Warehouse Association. Mr. Bennett Marsh of the law firm of Sandler and Travers accompanies me. He is counsel to the NBWA.

The NBWA and its member associations, including the Bonded Store Dealers of America, the United Export Trading Association, the Wine and Spirit Wholesalers of America, and the National Association of Beverage Importers strongly oppose the imposition of Customs user fees as a deficit reduction measure.

Our past experience with the Customs Service and its administration of user fees for bonded warehouses clearly indicates that such fees do not improve Government services to the export and import community. But, on the other hand, they result in dramatically increased costs. These costs already threaten the existence of many in-bond traders across the United States.

Three years ago the Customs Service introduced an audit inspection program to supervise and administer bonded warehouse activities. A user fee was imposed on bonded warehouses. It was calculated by taking the total cost of the program and dividing these costs by the total number of U.S. bonded warehouses. In 1984 the fee for the year was $650. With no explanation, in 1985 Customs more than doubled the fee to $1,400. Customs refused to provide an explanation for the increase.

Our association filed a Freedom of Information request, and we uncovered the fact that Customs had no accurate list of the bonded warehouses currently subject to audit and supervision. Moreover, their accounting information, released by Customs, indicated that the full yearly salary of personnel who have only minor responsibilities relating to the audit inspection program were counted toward the total program costs.

Past experience has convinced us that Customs is not committed to establishing a user fee schedule which is accurate and fair.

Prior to 1982, Customs provided actual services to bonded warehouses on a reimbursable basis. The user knew exactly what his costs would be, and Customs knew exactly what to charge. Under the current user fee system, Customs no longer provides any services, Customs doesn't know what to charge, and Customs doesn't know their own costs.

We must challenge the assertion that the Customs user fees would reimburse the Government for services rendered to exporters and importers.

Under the current user fee program, warehouse proprietors do not receive services from Customs. Actually, we serve Customs by holding bonded goods pending the collection of duties. Rather, we are investigated and policed, and our payments to Customs are used to fund an army of duplicative enforcement teams which actually impede the efficient operation of bonded warehouses.

Mr. Chairman, it would appear that under a new Customs user fee system we can almost be certain that the fee amounts will rise dramatically while services provided to the exporting and importing community will continually be contracted or curtailed entirely.

Given our first-hand experience with Customs user fees, we can only look upon this latest proposal as antibusiness and antitrade. A new rapidly escalating tax on bonded warehouses, foreign trade zones, border stores, duty-free shops, would actually reduce our ability as a nation to export goods and services. These new taxes would put many inbond traders out of business entirely.

Accordingly, we urge the committee to abandon the concept of Customs user fees and look to other means of reducing our Nation's budget deficit.

Mr. Chairman, thank you for the opportunity to testify.

[Mr. Gross' written testimony follows:]

TESTIMONY OF LAWRENCE GROSS, PRESIDENT OF VAN BRUNT WAREHOUSES, INC., ON BEHALF OF THE NATIONAL BONDED WAREHOUSE ASSOCIATION

Mr. Chairman and Members of the Committee on Finance, my name is Mr. Lawrence Gross. I am the President of Van Brunt Warehouses, Inc., of New Jersey, a corporation which operates several bonded warehouse facilities in the New York/New Jersey port area. Today, I would like to address you as a member of the Board of Directors of the National Bonded Warehouse Association. I am accompanied today by Mr. Bennett Marsh, of the law firm of Sandler & Travis, P.A. Sandler & Travis are chief counsel to the National Bonded Warehouse Association and represent, on an individual basis, many bonded warehouse proprietors across the United States.

The National Bonded Warehouse Association was formed in August of 1984, with the purpose of assisting bonded warehouse proprietors and other in-bond traders in their efforts to overcome serious problems related to a recently-adopted U.S. Customs Service audit-inspection program. Warehouse proprietors reimburse Customs for this supervisory program.

The National Bonded Warehouse Association consists of more than 180 of the largest bonded warehouse and duty-free shops in the United States. Although the major focus of Association activities relate to Customs administration of the bonding system, our membership spans container freight station operators, foreign trade zone operators, duty-free shops, bonded cartmen, freight forwarders, and customs brokers.

In addition to representing the National Bonded Warehouse Association, today we are speaking on behalf of the Bonded Store Dealers of America (which includes duty-free shops and suppliers across the United States), the United Export Trading Association (which includes border stores in the Southwestern United States), the Wine and Spirit Wholesalers of America Association, and the National Association of Beverage Importers.

Each of these associations strongly opposes the imposition of Customs user fees as a deficit reduction measure. In support of our position, we will detail our past experiences with Customs under the current audit-inspection fee system, and demonstrate how the inevitable abuse of this type of Customs fee system has resulted in business costs which threaten the existence of many in-bond traders across the United States. We will demonstrate with hard facts why an expanded program of user fees would more than double the burden on bonded warehouse proprietors, put most duty-free operations out of business, significantly decrease the profitability and advantages of foreign trade zones, and generally cripple the in-bond trade of the United States. Our past experience clearly indicates that Customs fees do not improve government services to the import and export communities, but rather result in dramatically increased costs to importers and exporters for enforcement and policing activities which are of questionable benefit.

Our story unfolds with the decision three years ago by U.S. Customs to supervise and administer bonded warehouse activities through an audit-inspection program. Under this program, Customs imposes a user fee on bonded warehouses, calculated by adding the total cost of the audit-inspection program and then dividing those costs by the total number of bonded warehouses in the country.

The annual fee in 1984 for the Customs program was $650. With no prior explanation or justification, Customs more than doubled the fee for 1985 -- to $1400. Stunned by the fee increase, and provided absolutely no explanation by Customs, the National Bonded Warehouse Association filed a Freedom of Information Act Request to obtain the accounting data used in the calculation of the 1985 annual fee.

The initial request for information was flatly denied by Customs. After an acrimonious administrative appeal, Customs reversed itself and provided certain cost figures used in calculating the fee. The information released by U.S. Customs indicates that the full yearly salaries of personnel who have only minor responsibilities related to the audit-inspection program are counted toward total program costs.

Although the annual bonded warehouse fee is calculated by dividing the number of bonded warehouses in the country into the total costs, our Freedom of Information Act Requests have uncovered that Customs has no accurate list of the bonded warehouses currently subject to audit and supervision. The NBWA filed Freedom of Information Act Requests on a district-by-district basis in order to obtain the Customs' lists used to calculate the number of bonded warehouses in the United States. After receiving those lists from Customs, the NBWA painstakingly crosschecked those lists with other sources of information and found that many lists were so old that they had neither dropped the names of bonded warehouses which have been out-of-business for years, nor picked up warehouses which had come into existence a year or more ago. We must again emphasize that the only reason this fee information became public, was through costly research and legal efforts by the National Bonded Warehouse Association.

These are two of many irregularities revealed by the Customs statistics. Regrettably, we cannot verify all the abuses because of the vague manner in which Customs disclosed its costs. For example, the New York Region attributed $136,650 in costs to spot checks of bonded warehouses; $44,301 in expenses to audits; and an incredible $576,678 in unsubstantiated miscellaneous costs, charged directly to bonded warehouse proprietors under this supposedly fair and equitable fee system. Perhaps we will find the same manipulation of cost figures when we explore the basis for the other user fee charged by Customs on bonded warehouses. This fee, charged for establishing or altering bonded warehouse facilities, rose twelvefold in two years--from $80 to $1,021.

Although our research is only in its preliminary stages, it appears likely that under the guise of reimbursing the government for its expenses, bonded warehouse proprietors pay the full salary of some Customs officers, while being charged, under a separate user fee statute, for estimated time spent by the same officers in performing a number of different tasks related to warehouses. Bonded warehouse proprietors are apparently being charged administrative overhead and overtime charges for Customs officers whose salaries have already been accounted for in other fee calculations.

Our objective in detailing these examples of inaccuracy and abuse under the current system of reimbursing the U.S. Customs Service is two-fold. First, past experience has shown us that absent strict Congressional scrutiny, Customs does not appear committed to calculating fees accurately and fairly. Second, in authorizing user fees, Congress is essentially giving Customs the authority to establish tax rates as it sees fit. The enactment of a broad range of user fees as proposed by Customs would create a nightmare of undisclosed and unaccounted for costs to the import and export community, and ultimately to the consumers of the United States.

Aside from our Association's fear of abuse, imposing fees on a broad range of Customs transactions is anti-business. Just one small group of border stores in Texas processes in excess of 33,000 entries and withdrawals in one year. This does not include in-bond transit, drawback filings, or many of the other specific transactions for which user fees have been suggested. User fees would destroy border store profitability on our southwestern and northern borders. Alcoholic beverage importers and wholesalers, likewise, would be severely damaged by these charges.

Duty-free shops, which process literally thousands of in-bond transactions on a daily basis, would be virtually taxed out of existence by user fees. Despite the fact that most duty-free Customs transactions are routine in nature, requiring only a few minutes of a Customs officer's time, the uniform user fee schedule which has been proposed would impose a significant cost on each transaction, regardless of its complexity. Duty-free operators will be paying millions of dollars per year in user fee charges, for services costing the U.S. Government a fraction of the revenues collected.

Foreign trade zones, which in some circumstances provide an alternative for certain types of export transactions, would be rendered unprofitable by a user fee on each transaction.

Perhaps the most disturbing aspect of the Customs user fees debate is the contention that Customs user fees would reimburse the government for services rendered to importers and exporters.

Here, we must ask ourselves who is really served by Customs? Primarily, Customs acts as an enforcement agency, enforcing the rules and regulations of agencies such as the Food and Drug Administration and the Bureau of Alcohol, Tobacco and Firearms. Indeed, the domestic industry, not the importer, is served by Customs enforcement of such regulations as country-of-origin and marking requirements, textile quotas, anti-smuggling and counterfeiting regulations, and collection of anti-dumping duties. The Commissioner of Customs reportedly has even gone so far as to suggest that Customs should change its name back to "Bureau" instead of "Service" because it is an enforcement agency, not an agency which provides services for importers and exporters.

In our experience with the current bonding program, bonded warehouse proprietors have not been served by Customs; they have been investigated and policed to protect the public and the laws of the United States. The government is thus proposing to tax importers and exporters in order to make certain they are being properly taxed. Our experience has shown us that Customs user fees are easily turned into a means for funding an army of duplicative enforcement teams which seriously impede the operations of bonded warehouses.

When enacting the User Fee Statute in 1950, Congress, undertook an extensive study to determine the difference between enforcement services accruing to the benefit of the general public, and services to individuals provided by the government.

That study produced concrete examples indicating that it is not in the public interest to levy Customs user fees to support enforcement efforts. Because Customs users fees will, judging by past experience, be used for overall policing and fiscal measures, and will not in any way represent a specific reimbursement for services rendered, Customs user fees would constitute nothing more than a taxation of imports and exports for fiscal purposes. This is in complete violation of the General Agreement on Tariffs and Trade.

In conclusion, Mr. Chairman, our experience with Customs fees have shown us that we can be almost certain that the fee amount will rise dramatically, while the quality of service to the importing and exporting community will continually decrease.

Custom user fees should not be looked upon as a necessary fiscal measure, thereby ignoring their impact on the import-export business community. The fees proposed by Customs would significantly negate the Congressional purpose behind foreign trade zones, would put many small bonded warehouses out of business, would devastate the border stores of the United States, and would cost many duty-free shops and liquor wholesalers millions of dollars, threatening their continued existence. In short, most in-bond traders of the United States could simply not survive the user fee proposal made by the Administration.

On behalf of all our associations and in the interests of the ultimate consumers and the labor force of the United States, who would bear many of the consequences of these costs, we urge the Committee to abandon the concept of Customs user fees, and concentrate on the abuses in the current bonding system which allow Customs to operate inefficiently and ineffectively.

Mr. Chairman, Members of the Committee, we wish to thank you for this opportunity to comment on what we view as the most serious threat to the in-bond community in recent history.

The CHAIRMAN. I have a question about tariffs.

No one here contends—do they?—that tariffs are user fees.

Mr. O'CONNOR. No, sir. I don't.

The CHAIRMAN. So that the argument that Customs collects 20 times as much money as it costs to run it and the fact that they are collecting tariffs is not an argument in and of itself that the cost of running the Customs Service should be paid for out of the tariffs, any more than the cost of the IRS should be paid for or earmarked specifically out of the moneys that they collect from the general taxpayer.

Mr. O'CONNOR. That is correct.

Mr. SHOSTAK. Mr. Chairman, the Grace Commission pointed out that the processing by Customs of formal and informal entries of goods and entries by mail are services that support the general economy, for which a fee has already been paid in the form of the duty on the goods or the postage.

So, I believe it is incorporated when duties are fixed by Congress or otherwise.

The CHAIRMAN. When you say duties, do you mean tariffs?

Ms. SHOSTAK. We mean tariffs, yes.

The CHAIRMAN. Well, I don't want to disabuse you, but that is not Congress' concept. We do not regard tariffs as user fees. We raise them or lower them. Sometimes it has to do with international trade and competition in quotas, sometimes it is just to collect money. But it is not intended in our mind as a user fee.

Ms. SHOSTAK. No, not as a user fee. But the Grace Commission did not approve user fees for entry.

The CHAIRMAN. No; I know that.

Ms. SHOSTAK. And it pointed out that there should not be any, because the tariffs more than compensated the Government for whatever services were required.

The CHAIRMAN. All right.

Here is what we are moving down the road toward, however. Take the U.S. Forest Service. The Forest Service sells great quantities of timber off the public forests, infinitely more than it costs to run the Forest Service. We don't say that the Forest Service ought to be run off those. They go into the general fund, and we are now moving toward some user fees, interestingly, in Forest Service sales. We are just about to go down the road toward both port and additional waterway user fees. We say if ports want to build up their ports, they are going to have to pay part of it. And they can also levy user fees. And we are going to levy additional user fees on barge operators.

What I don't grasp is the theoretical or philosophical difference between so-called Customs user fees and a whole variety of others. This is assuming they were genuine fees; I am not going to talk about overcharging or excessive charging. I mean genuine fees for the cost of running the Customs Service. How would that differ from other user fees we are going to be imposing in a whole variety of areas for the cost of providing certain services?

Mr. O'CONNOR. Mr. Chairman, I would like to comment on that, if I may.

Many of the people sitting up here representing industry associations already are assessed user fees—the Bonded Warehouse Association, the Foreign Trade Zone Association, the Air Transport Association already pay Customs user fees for specific identified services. I think that is a major difference between us and maybe the Forest Service.

The CHAIRMAN. Well, indeed it is a major difference, and I realize that you have overtime services and you have special services. You pay for them.

I am not here arguing that you should pay more than the cost of the services; the question is: Should there be Customs user fees for the cost of the services, assuming we could agree what those are?

Mr. O'CONNOR. In our case, in the Foreign Trade Zone industry, there already are. We pay 137 percent of every officer they assign.

The CHAIRMAN. Now, I want you to listen to my question. I understand that.

Mr. O'CONNOR. OK.

The CHAIRMAN. Should there be Customs user fees for the cost of Customs functions?

Mr. KUMM. I think it is the difference between the user fees that you are talking about in the area of the Forest Service and so forth. That is a voluntary service; it is selected by the individual utilizing the service or the person utilizing the port. In the case of Customs operations it is a service which is required by the Government for the Nation as a whole, to service the Nation as a whole, to protect the borders, if you will.

In addition, they perform a commercial service or a commercial activity, I should say, which is the collection of the duty. We would certainly like to do away with any of that service if we possibly could; but it is not voluntary. It is like paying your income tax. And I think that has been stated many, many times before.

Mr. ST. JOHN. Mr. Chairman, there are many, many other services that are connected with an import transaction for which the importer has little concern. But the Government and the public as a whole does. For example, the Environmental Protection Agency imposes law, laws that they administer. Customs stands in their position and provides certain services in order to review the shipment for the administration of that law. You have the same situation with the Department of Transportation.

There are many, many laws that are administered for the public good that perhaps don't have a particular direct relationship to that importation; but, in order to protect the public, enforcement has to be available and has to be provided. And those costs are built into what the Customs Service does.

A second point is, in arriving at Customs costs, I notice that they have separated enforcement. However, in the routine handling of a shipment there is considerable review of documentation and shipments, not so much to determine duty of value, in order that the importer pays the proper amounts, but to see that many of the other problems are taken care of with that shipment. It is enforcement activity that reviews not only that shipment but many things that relate to it.

Mr. LANDRY. If I could make a couple of points, Mr. Chairman. I noticed that the Deputy Commissioner this morning indicated that they would be inspecting some 33 million air passengers a year, and he estimated the cost, including some undefined amount of overtime, at $2 per head. That comes to $66 million. And I can say that the airline industry right now is paying roughly $67 million for that Customs service. We pay $23 million in overtime right now. We pay some $40 million for the rental and maintenance of the Customs facilities at all of the airports. We pick up that tab. And we pay $4 million for excess preclearance costs up in Canada and in Bermuda and the Bahamas.

I might mention one other thing if I could, Mr. Chairman. I noticed the Deputy Commissioner's prepared statement referred to the situation back in 1840 when they were searching even then for ways to reduce Customs' costs. I wonder if one might not take a look at what our forefathers had created at that point in time and what was being done. And that was that when the duties collected were brought in, they took off the top the cost of providing the Customs Service and submitted the rest to the general fund. That went on until the 1860's and indeed today goes on in Puerto Rico and the Virgin Islands. It is a very sensible system. The rest went into the general fund and up until income taxes ran the Government.

The CHAIRMAN. That is true, up until that time. Until we had the income tax, we ran almost totally off the tariffs.

Mr. O'CONNOR. Mr. Packwood, in answer to your question specifically, the National Association of Foreign Trade Zones would like to state that we do not believe user fees should be charged by the U.S. Customs Service.

The CHAIRMAN. Thank you.

No other questions?

[No response.]

The CHAIRMAN. I appreciate it. We are adjourned.

[Whereupon, at 12:02 p.m., the hearing was concluded.]

BUDGET RECONCILIATION

THURSDAY, SEPTEMBER 12, 1985

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room SD-215, Dirksen Senate Office Building, the Honorable Robert Packwood (chairman) presiding.

Present: Senators Packwood, Heinz, Durenberger, Grassley, Long, Bentsen, Baucus, Bradley, and Mitchell.

[The opening statement of Senator George Mitchell follows:]

STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I want to thank you for having scheduled this hearing today to discuss a number of proposals in the Medicare and Medicaid Programs. I am especially pleased to have an opportunity to hear testimony from Secretary Heckler, as well as a number of others who are recognized experts in their respective fields.

The objective of our hearing today, and in fact, the legislation before the committee, is to reduce the deficit. There is no one more committed to that goal than I. In working towards the reduction of the deficit, however, we must not forget our responsibility to those Americans who rely on the Medicare and Medicaid Programs for their health care.

The implementation of the Prospective Payment System in the Medicare Program has been successful in dramatically reducing the rate of inflation in hospital costs. This committee can be proud of its role in reducing these soaring costs during the past two years.

The Prospective Payment System has not been without problems and shortcomings however. We must continue to emphasize quality of care for the elderly and poor beneficiaries of Medicare and Medicaid. In working to reduce the deficit and the enormous costs of these programs, let us not forget the health and dignity of those persons we are elected to represent.

We must also be cognizant of the health of the nation's hospitals. Many small, rural hospitals in my home state of Maine are having financial problems under the Prospective Payment System. We must continue to listen to the concerns of our hospitals with regard to reimbursement under the urban and rural rates, reimbursement for medical education and other issues which affect both the health of our nation's hospitals and the health care of our citizens.

I look forward to Secretary Heckler's testimony as well as testimony from other witnesses representing hospitals and the elderly. I hope this committee will be able to work out a package that will reduce spending withoug jeopardizing the quality of health care of the nation's hospitals and other health care facilities are able to provide for beneficiaries of the Medicare and Medicaid Programs.

The CHAIRMAN. The hearing will come to order, please.

Today's hearing is going to focus on spending reductions in the Medicare and Medicaid Programs. As the audience is aware and the committee members know, we have a September 27 date to meet for budget reconciliation purposes and a fair number of the spending reductions ordered for this committee are in the Medicare and Medicaid Programs. We have to meet a total of about $22 billion in spending reductions, and by far the largest portion of them come from those two programs.

If this committee doesn't meet them, doesn't report by the September 27 on our suggested cuts, then the Budget Committee is free to make them as they want in those areas, and they will.

So, the choice is not are they going to be made or not going to be made. The question is: Are they going to be made by us or by them? And if they are made by the Budget Committee, would they be significantly different types of cuts than we might make.

I would prefer that if they must be made, we make them. At least we have dealt with these programs for the better part of 20 years and have a little bit more knowledge, background, and experience in them than I think the Budget Committee does.

Our first witness today is my colleague from the State of Washington, Senator Dan Evans.

Good morning, Dan.

Senator EVANS. Good morning, Mr. Chairman.

The CHAIRMAN. Go right ahead.

STATEMENT OF THE HONORABLE DANIEL J. EVANS, U. S. SENATOR FROM THE STATE OF WASHINGTON

Senator EVANS. Mr. Chairman, I ask that my full statement be included in the record. I will try to be brief. I know you have a long and difficult agenda, and I probably won't make that it any easier for you by a proposal I will make, that is not likely to save any money, at least not initially.

But I do want to speak about an issue which I have a good deal of experience—both from my current position as a Senator, and even more as Governor of the State of Washington, where I had to go through, along with my colleagues then and now as Governors, a long, tedious, difficult, and often contentious conflict with the Department of Health and Human Services over the measurement of error rates in the field of Aid to Families with Dependent Children. Or for that matter, some of the other categories of aid, which are shared, as we sometimes forget in terms of financing, between the States and the Federal Government.

I have introduced legislation along with 31 of my colleagues, many of whom serve on this committee, to improve the existing quality control system in AFDC. The benefits of providing States with a more effective management tool far exceed any costs of legislation.

The House has already included similar AFDC reform provisions in its deficit-reduction package. However, I do not believe the House measure adequately addresses the problems within the existing intergovernmental relationships in AFDC.

This area is most important because our existing Federal-State partnership in the administration of AFDC, in my view, is in a state of utter chaos. And my legislation is aimed at this particular problem.

Recently, the Secretary of HHS levied $70 million in liability against 21 States for fiscal year 1981, nearly half of whom had error rates which were below the national average. An estimated $93 million will be levied against 25 States in fiscal 1982. An estimated $178 million will be levied against 36 States in fiscal 1983. Nearly three-quarters of these States had error rates below the national average of 6½ percent.

After 3 years of AFDC fiscal penalties, only nine States have not received a sanction.

Mr. Chairman, any time you have a system in which all but nine States of the Union are placed under fiscal sanction, I think that shouts pretty loudly that the system is wrong; not that the States are wrong.

I cannot believe that 41 out of 50 States are either incompetent or are willfully attempting to evade the law. They all have a stake in management of error rates. Every State has its own money involved in the benefits that go for Aid to Families with Dependent Children.

It is a clear indication that something is wrong with the system. My proposal is one that will allow us to engage in a significant study; to hold standards at a reasonable level while we are doing so; to not proceed so aggressively in this sanction arena; and to embark on a system of incentives, which I believe are far more likely to bring results than fiscal penalties, which are levied but which I might point out, Mr. Chairman, to this date have never been collected. Not one dime has been collected by the Federal Government, and they are not likely to collect any for some period of time in the future because it's my understanding every State will vigorously oppose in the courts, if necessary, the levying of these sanctions, making a compelling case that they are grossly out of line.

I would like to point out one of the major areas in which this system has some rather bizarre results.

I saw my colleague from Minnesota step in, and I hope that he has a chance to read this part of the testimony.

The Federal Government counts technical errors which often distort the State's performance record. My legislation would not consider technical errors in determining a State's error rate. These errors relate to administrative requirements, such as WIN registration and assignment of Social Security numbers to all welfare recipients.

Correction of these errors have no fiscal impact because they often will make clients eligible for the program; not eliminate them from the roll.

And let me use one very good and not very unique example. Minnesota is one of the 28 States penalized for failing to meet its fiscal year 1981 target rate. In fiscal year 1981, Minnesota's AFDC quality control sample contained three cases that were not registered for WIN and should have been.

Because these three cases were in the Federal subsample, their impact on the official error rate was greatly exaggerated because of the statistical procedures used. The effect was to increase the State's error rate from 3.1 percent, well below the Federal tolerance, to 4.4 percent.

Just those three cases, none of which had any fiscal impact, from 3.1 to 4.4 percent; thereby, subjected the State to a significant fiscal sanction.

Administrators in my own State told me about one case involving a low-income mother and her child who were eligible for AFDC. The mother obtained a Social Security number for her child, but did not understand that she had to report it to the welfare office.

The existing quality control system, which counts technical errors such as this one, found both the mother and her child ineligible. The State was sanctioned for the entire amount of the grant, which was extrapolated over the entire caseload that is measured to determine the error rate.

The end result not only overstates the actual error rate, but it measures an error that has nothing to do with the need or the eligibility of the AFDC recipient.

Mr. Chairman, I have attached to my testimony some tables which list the States and the amounts of sanction, their error rates and the Federal tolerance. It's interesting to note that under our current, I would suggest, bizarre system, some States with quite significant error rates do not face Federal sanctions while other States who have done a good job all the way through and have a considerably lower error rate do face sanctions.

Let me just end by saying what I said at the beginning. Anytime you have a system in which 41 States are declared to be out of bounds and subject to fiscal sanctions, that suggests to me that something is wrong with the system; not something is wrong with the States.

And I hope, Mr. Chairman, that you and the committee will see fit to add the essence of the bill I have introduced to this proposal. In my view, S. 1362 takes a long step toward encouraging lower error rates, measuring them in an appropriate fashion and giving us time to accomplish these objectives.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared written statement of Senator Evans follows:]

STATMENT OF SENATOR DANIEL J. EVANS

Mr. Chairman, as the Committee takes up the difficult task of deficit reduction I urge that you pay particular attention to the need to reform the fiscal sanctions component of AFDC quality control. I have introduced legislation along with 31 of my colleagues, many of whom serve on this Committee, to improve the existing quality control system in AFDC. The benefit of providing states with a more effective management tool far exceed the costs of the legislation. The House has included similar AFDC reform provisions in its deficit reduction package. However, the House measure does not adequately address the problems with the existing intergovernmental relationship in AFDC. This area is most important because our existing federal-state partnership in the administration of AFDC program is in a state of utter chaos. My legislation is directed at this fundamental problem. For reasons I will outline shortly, I urge that the Committee include the major provisions of S. 1362 in the reconciliation measure it will report to the full Senate.

Recently, the Secretary of HHS levied $70 million in liability against 21 states for FY°81, nearly half of whom had error rates below the national average. An estimated $93 million will be levied against 25 states in FY°82 and an estimated $178 million will be levied against 36 states in FY°83. Nearly three-fourths of these states had error rates below the national average of 6.5%. After three years of AFDC fiscal penalties only nine states have not received a sanction. Mr. Chairman, at the conclusion of my remarks I would ask that the following tables be included in the record detailing the fiscal sanctions I have discussed.

Over the past decade, states have made sizeable progress in reducing errors. Without official collection of any fiscal sanctions by the federal government, the AFDC payment error rate has been reduced from 16.5% in 1973 to an official 6.7% in September, 1982. The most significant progress in state error reduction took place from 1973 to 1980 -- a period when no fiscal sanctions were imposed. While I strongly believe we should continue to maintain federal quality control guidelines to which the states must adhere, I am deeply concerned with the arbitrary and inequitable nature of existing standards. The purpose of quality control is to help states improve AFDC administration and reduce errors. Its purpose is not to force states to develop unduly restrictive eligibility requirements. Its purpose is not to shift AFDC costs from federal to state budgets which will inevitably result in higher AFDC errors in the future. The purpose of quality control is to provide states with an effective management tool so that program administration can be as cost-efficient as possible. Such an objective must be an integral part of our goal of deficit reduction.

If we do not initiate comprehensive and principled reforms in AFDC quality control, states will be severely and unduly penalized. For example, Governor Madeleine Kunin of Vermont testified recently before the House Ways and Means Committee that a fiscal sanction as small as $700,000 against her state would have serious repercussions. Governor Kunin pointed out that the loss of a 50% federal match of $700,000 was actually a loss of $1.4 million. She went on to speculate that actions to absorb this loss would consist of cutting training of program personnel by half and termination of systems development efforts -- systems, ironically, that are put in place to reduce errors.

Other actions would include laying off field workers and readjusting overhead costs so that they could be spread over to other programs. In other words, these sanctions will serve as punitive measures against states and lead to results that Congress clearly did not intend.

Undoubtedly, states will have to absorb such cutbacks through reducing administrative costs which will result in even higher rates of error. Or, states will pass on the financial burden to AFDC recipients through reduced or restricted benefits.

My own State of Washington is in the process of a slow recovery from its recession and this means that state revenues are already thinly spread. It is likely that fiscal sanctions would have to be paid by reducing welfare grants or by limiting medical services to the poor. This action would hurt the very people the programs are designed to serve. Furthermore, the impact is greatly amplified when we consider that funding for AFDC has been cut dramatically in recent years. In essence, existing fiscal sanctions amount to nothing more than additional, back-door cuts in AFDC.

The need for legislative reform is imperative because our existing system prevents rather than assists states in error reduction. The current tolerance level of 3 percent was established by TEFRA in 1982. This percentage was arrived at arbitrarily and is not supported by any conclusive research. It fails to take into account economic conditions as well as signficant geographic and program differences among the states. These factors often contribute to errors in ways largely beyond the control of states.

S. 1362 would require HHS and the National Academy of Sciences to conduct concurrent studies to determine what the tolerable error rate for states would be. Both have already done considerable work in this area. For example, in 1982, an unpublished HHS study found that such outside factors as greater population density, higher crime rates, sizes of local population and size of the welfare agencies° caseloads contribute significantly to higher error rates. Despite such findings, however, HHS makes no effort to consider these factors when determining a state°s error liability.

Until the actual tolerable rate of error can be documented and established, S. 1362 would impose a moratorium on collection procedures during the interim period. It would also provide relief from a procedure that is costly to both the federal and state governments. I must emphasize that the federal government has collected nothing through fiscal sanctions since the current practice was established in 1981. This factor should be taken into account as the Committee estimates potential costs of quality control reform. Another important factor is the large discrepancy between HHS and CBO baselines assumptions for the collection of AFDC error rate penalties. HHS has estimated it will collect over $1 billion in sanctions for fiscal years 1981-1989 with the first year of collection beginning in FY°84. The estimate is already inaccurate. CBO, on the other hand, estimates that collection will not begin until FY°88 and it will only be partial collection from previous fiscal years. Collection may be further delayed by the strong likelihood that states will seek relief from sanctions in court. With the cost of program administration and potential litigation the existing quality control system will cost us more to administer in the years to come than we can anticipate to recover in revenues.

My legislation would return the tolerance target to 4%, the existing level before TEFRA lowered it in 1982. The 4% target would remain in effect until an actual national error rate could be established.

In assessing error rates, the federal government currently takes the best of both worlds when it applies sanctions based on the midpoint of the state error rate range. My legislation would require the federal government to use the lower bound of the confidence interval as the official statistical error rate. The lower bound is the best estimate because it will provide the federal and state governments with a 98% probability that the official error rate is not an overestimate. As a punitive measure, fiscal sanctions should be imposed on the lower bound or the most accurate estimate of a state°s actual error rate. The validity of using the lower end of the confidence interval has been recognized by leading economists and other federal agencies. For example, the IRS has determined that the lower bound of the confidence interval should be used for the purpose of sampling-based tax adjustments.

The federal government also counts technical errors which often distort states° performance record. My legislation would not consider technical errors in determining a state°s error rate. These errors relate to administrative requirements such as WIN registration and assignment of social security numbers to all welfare recipients. Correction of these errors have no fiscal impact because they often will make clients eligible for the program, not eliminate them from the rolls.

Minnesota, for example, is one of the 28 states penalized for failing to meet its FY°81 target rate. In FY°81 Minnesota°s AFDC quality control sample contained three cases that were not registered for WIN and should have been. Because these three cases were in the federal subsample, their impact on the official error rate was greatly exaggerated because of the statistical procedures used. The effect was to increase the state°s error rate from 3.1%, well below the federal tolerance, to 4.4%, thereby subjecting the state to a fiscal sanction.

Administrators in my state told me about one case involving a low-income mother and her child who are eligible for AFDC. The mother obtained a social security number for her child but did not understand that she had to report it to the welfare office. The existing quality control system which counts technical errors such as this found both the mother and her child ineligible. The state was sanctioned for the entire amount of the grant which was extrapolated over the entire caseload that is measured to determine the error rate. The end result not only overstates the actual error rate; but it measures an error that has nothing to do with the need or eligibility of the AFDC recipient.

Mr. Chairman, I have seen this issue from both a state and federal perspective. In my view, our existing policy lacks a principled foundation. Quality control is a management tool that must provide incentives, not disincentives to states for efficient and cost-effective program administration. Thus, I believe reform in this area is essential to our deficit reduction efforts.

The issue is also one of critical intergovernmental importance. In practice, our existing quality control system has lead to results that Congress clearly did not intend and we have a responsibility to to put it back on solid footing by restoring its usefulness as a management tool.

The provisions of S. 1362 would go far in resolving the fundamental flaws of the AFDC quality control system. I urge the Committee to incorporate its major provisions in the reconciliation measure. To this end I would be happy to work with you in developing a proposal that is both acceptable to the Committee and responsive to the existing short-comings of AFDC fiscal sanctions.

-Thank you.

FY'81 ERROR RATE SANCTIONS FOR AFDC

State	Amount of Sanction	State Error Rate	Federal Tolerance
Alabama	47,000	7.7 %	7.6 %
California	35,067,000	6.8	4.0
Colorado	1,898,000	8.2	4.2
Connecticut	424,000	7.4	7.1
Florida	3,467,000	7.9	5.1
Hawaii	1,212,000	10.1	7.5
Idaho	691,000	9.1	4.3
Indiana	113,000	4.1	4.0
Kansas	1,903,000	8.1	4.1
Maine	168,000	7.9	7.5
Minnesota	571,000	4.4	4.0
New Mexico	2,554,000	12.4	4.5
Nebraska	280,000	5.5	4.4
New York	6,270,000	8.0	7.2
Ohio	3,935,000	8.9	7.7
Oklahoma	1,508,000	6.6	4.0
South Dakota	13,000	4.6	4.5
Tennessee	1,754,000	8.9	6.0
Texas	1,112,000	7.5	5.9
Washington	4,162,000	9.3	5.8
Wyoming	413,000	13.7	4.0

Note: The national average error rate in FY'81 for AFDC was 7.7 percent.

FISCAL YEAR 1982 ERROR RATE SANCTIONS FOR AFDC

State	Amount of Sanction	State Error Rate	Federal Tolerance
Arizona	1,100,000	11.6 %	5.3 %
Arkansas	200,000	7.0	5.7
California	27,200,000	6.0	4.0
Colorado	1,300,000	6.6	4.1
Connecticut	900,000	6.0	5.5
Delaware	500,000	11.9	8.0
Hawaii	1,100,000	8.2	5.7
Idaho	200,000	5.4	4.1
Maryland	1,100,000	8.2	7.2
Michigan	13,200,000	8.2	5.7
Nebraska	1,500,000	9.6	4.2
New Jersey	3,900,000	7.3	5.8
New Mexico	1,800,000	10.5	4.3
New York	19,900,000	8.0	5.6
Ohio	6,000,000	7.6	5.8
Oregon	100,000	7.1	6.9
Pennsylvania	1,700,000	8.5	8.1
South Carolina	2,600,000	8.9	5.0
Texas	2,600,000	8.4	5.0
Utah	3,000,000	5.0	4.0
Vermont	100,000	4.5	4.2
Washington	1,800,000	6.4	4.9
West Virginia	700,000	8.2	6.4
Wisconsin	200,000	6.5	6.4
Wyoming	100,000	4.8	4.0

Note: the national average error rate in FY'82 for AFDC was 6.9%

*sanction amounts are estimates based on available national data

FY'83 ERROR RATE SANCTIONS FOR AFDC

State	Amount of Sanction	State Error Rate	Federal Tolerance
Alaska	1,700,000	15.5 %	4.0 %
Arizona	2,300,000	10.0	4.0
Arkansas	200,000	4.9	4.0
California	12,800,000	4.8	4.0
Colorado	1,100,000	6.2	4.0
Connecticut	400,000	4.4	4.0
Delaware	700,000	9.4	4.0
Florida	700,000	4.5	4.0
Georgia	2,100,000	5.7	4.0
Hawaii	1,200,000	6.9	4.0
Illinois	11,500,000	6.8	4.0
Indiana	700,000	4.9	4.0
Kansas	500,000	5.1	4.0
Louisiana	1,500,000	5.7	4.0
Maine	200,000	4.5	4.0
Maryland	1,500,000	5.3	4.0
Massachusetts	16,500,000	11.4	4.0
Michigan	28,100,000	9.1	4.0
Nebraska	2,100,000	4.7	4.0
New Hampshire	100,000	4.3	4.0
New Jersey	5,900,000	6.4	4.0
New Mexico	700,000	6.3	4.0
New York	46,800,000	9.4	4.0
Ohio	5,700,000	5.6	4.0
Oklahoma	100,000	4.1	4.0
Oregon	100,000	6.0	4.0
Pennsylvania	21,200,000	9.1	4.0
Rhode Island	900,000	6.2	4.0
South Carolina	1,700,000	7.1	4.0
Tennessee	300,000	4.5	4.0
Texas	3,000,000	7.2	4.0
Utah	600,000	5.7	4.0
Vermont	900,000	7.9	4.0
Washington	1,000,000	4.8	4.0
Wisconsin	3,000,000	5.1	4.0
Wyoming	200,000	7.7	4.0

Note: the national average error rate in FY'83 for AFDC was 6.5 percent

*the sanction amounts are estimates based on available national data

September 10, 1985

PRELIMINARY CBO COST ESTIMATES OF S. 1362
(in millions)

	FY'86	FY'87	FY'88	FY'89	FY'90
study costs	$ 2	$ 1	--	--	--
2yr moratorium FY'86-FY'87	0	0	--	--	--
lower bound technical errors .04 tolerance level	--	--	49	168	193
incentive payments	--	--	40	45	47
totals.................	$ 2	$ 1	89	213	240

TOTAL..................$544

TOTAL LESS INCENTIVES...412

ASSUMPTIONS FOR COLLECTIONS OF AFDC ERROR RATE PENALTIES
(in millions)

	HHS	CBO	S.1362
FY'84: collect for errors in FY'81	$ 74	0	0
FY'85: collect for FY'82,83-84	513	0	0
FY'86: collect for FY'85	198	0	0
FY'87: collect for FY'86	198	0	0
FY'88: collect for FY'87	175	*87	38
FY'89: collect for FY'88	159	247	79
TOTALS..................	$1,339	$334	$117

* CBO estimates FY'88 will be partial collection only for previous fiscal years

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, let me endorse what Senator Evans has so lucidly played out for us. I don't think there was any design to use Minnesota. We are just going to pick examples around the country with the problem.

Senator EVANS. Just 1 of 41.

Senator DURENBERGER. And I guess every year, Dan, we deal here in one way or another in a budgetary sense with this particular issue. And I agree with you in terms of the waste, fraud, and abuse. We have come a whale of a long way in a number of years as the States have gotten used to what the ground rules may be in the program.

Are there some areas in which we can achieve some savings that fall in the whole area of quality control, or have we pretty well gone through that system and achieved whatever so-called savings there might be without drastically changing the whole AFDC system?

Senator EVANS. I think it's difficult to keep pushing error rates down. We can work at it, but, frankly, unless we drastically simplify the system—I'm not sure that that's possible to do, but unless we drastically simplify the system, I think it's very difficult to expect that we are going to get error rates down to 1, 2 or even 3 percent.

I had an opportunity some years ago to point out to then-Vice President Rockefeller the frustrations of the States, and did so by laying on the witness table the books which a typical welfare caseworker has to know and understand in order to determine eligibility of various people for welfare programs.

And those books stand about a foot high. No wonder that there are some errors.

But the way we measure them currently and the kinds of sanctions that have been applied to States just as often come from the technical errors, which I mentioned, magnified by the sampling procedures used and then translated into serious fiscal penalties, which I simply do not think are justified.

Now, admittedly, I am coming before you at a time when you are seeking further cuts and ways to keep the budget under control. And this probably has some cost attached to it.

However, I believe in the long run it will prove beneficial in keeping error rates down and bringing them down ever further.

Senator DURENBERGER. Aren't we also at the point, though, where there are other larger factors at work in the so-called error rates thing over which even the best run program doesn't have any control? I mean the certain kinds of population density, the changes in the economy and the work force and the difference in crime rates and different nature.

I mean there are a whole lot of those other factors that nobody's public health or welfare department at any State level, you know, can change that really is at the heart of that first 3 percent or 4 percent or whatever it is.

Senator EVANS. I think you are absolutely right. And that's the focus, really, of the proposal that I have made, which is to conduct a study immediately to tell us some of those things; to recognize, as I think we ought to recognize, that there are significantly greater difficulties, just in terms of error rate, but also in terms of the broad management of a welfare program, in some of our urban, large centers as opposed to perhaps a rural and easier to manage setting.

And I think those differences, very likely, ought to be recognized as we establish the goals which are legitimate goals, I think, for error rates. But, again, when you get 41 States purportedly violating a standard, then I think we ought to look pretty seriously at the standard.

Senator DURENBERGER. Well, I am grateful for your coming here. And I just hope, Mr. Chairman, that we will take his advice.

The CHAIRMAN. Senator Bentsen.

Senator BENTSEN. Well, I think it is a contribution, which you have stated, Governor. I have one of those States that has fines levied against it in this regard.

Let me understand your incentive payment. With the problem that we face on this committee in trying to make the cuts that are necessary to meet the budget resolution, I'd like to have a little better idea of your provision in there to keep the error rate less than 4 percent.

What kind of a cost would be involved in that?

Senator EVANS. Well, of course, it's not easy to determine because that would depend on how many States ultimately bring their error rates down below the Federal standard and qualify for incentive payments.

The CBO has estimated that in fiscal years 1988, 1989, and 1990, some distance out yet, that those incentive payments could be in the $40 million range. That has to be an estimate, of course.

But recognize that if we get to the point of incentive payment, that means that the error rates themselves are down very substantially, and that, in itself, is a significant savings.

Senator BENTSEN. Right.

Senator EVANS. So I think that what I am suggesting is that the incentive payments would be merely a sharing of the savings which would occur from bringing error rates down. And, frankly, I think that kind of incentive would do a whole lot more than these rather arbitrary sanctions in bringing error rates down and saving money both for the States and for the Federal Government.

Senator BENTSEN. Senator, I think your testimony has been very helpful.

The Chairman. Senator Heinz.

Senator HEINZ. Mr. Chairman, I want to commend Senator Evans on a proposal that I think there is a lot of sympathy for. I have some serious interest in it. I, too, am concerned, however, about the cost of the proposal, which is admittedly difficult to calculate.

One alternative to Senator Evans' proposal or something that which might work with Senator Evans' proposal is to get the States to do a better job of automating their AFDC systems. Following the Schweiker amendment of 1980, 49 out of 50 States have used automatic data processing for Medicaid. As of today, only 3 of 50 States, all of which have been given a 90-percent Federal cost reimbursement for any money spent automating their systems for AFDC, have been certified as having those operable and only 5 other States have applied.

Senator, how would you feel about a proposal which I have introduced previously in bill form which would require States to meet their own deadlines for automation—they have set deadlines—or pay back their incentive funding if they don't do so?

It seems to me what we have right now is a kind of open draw on the Federal Treasury. It's great for all the consultants and equipment companies, but it hasn't produced much of anything.

Senator **Evans**. Well, certainly I think if a contract is entered into and goals are set and they are not met, either there has to be a pretty legitimate reason for not doing so or certainly States ought then to pay the Federal Government back.

I think we ought to keep in mind, however, that—that the AFDC Program, particularly, is more complex by a country mile than virtually any of the programs which States must administer.

It means, therefore, that it is just significantly more difficult to come up with an adequate kind of automation program. And we always have to keep in mind that in a complex program, you can automate it all you want, but it depends in the ultimate analysis on the accuracy of information being fed into the automated equipment. And what you do with the information that comes out the other end.

And I think the only way to get at that problem, to the degree we can, is to try to simplify the program. And that's a difficult task, indeed.

Right now, the program is so complex with so many requirements on those caseworkers that it's no wonder that they sometimes make errors, many of them technical.

Senator **Heinz**. How would you respond to the fact, though, that three States have actually automated and another five claim that they have done so, and have applied for certification? It seems to me that if eight States, in fact, can meet the challenge of dealing with all that complexity, it's not too much to ask, given a reasonable period of time, that the rest do so as well.

Senator **Evans**. I suspect that that is true. I don't know which States those are that have already accomplished that, whether they are the large States or States which have a smaller problem in terms of AFDC. I am not aware of which States have done that.

But, certainly, from my own experience as Governor, we find that once one State has found a better way to do something, that idea is spread fairly rapidly from one State to another. And I would hope that those States which have done it successfully would have that material transmitted to the others.

Senator **Heinz**. I'm advised that one of the States that has done so successfully was Wisconsin.

Senator **Evans**. Which is certainly a significantly sized State. I understand Wisconsin has always done a pretty good job, in this area.

Senator **Heinz**. Thank you.

Senator **Evans**. I might just point out, Mr. Chairman, and to my colleague from Pennsylvania, that in terms of costs—for the next 2 fiscal years, which I think are 2 critical years that we have to deal with, there is essentially no cost to this legislation. It's just a cost of the study that is called for in the bill. The kind of costs that the CBO assigns to S. 1362 are costs which come in fiscal years 1988, 1989 and 1990, when an incentive program might begin.

The CHAIRMAN. Senator Mitchell.

Senator MITCHELL. Thank you, Mr. Chairman.

I want to commend Senator Evans for his efforts in this area. This is a very difficult program. We all want very obviously to reduce error rates to the extent possible; minimize the waste of valuable Federal resources. At the same time, it must be done in a manner that is equitable and can be fairly administered.

I am one of the cosponsors on Senator Evans' bill, and I look forward to working with him and the other members of the committee in attempting to achieve some equitable solution to what is a difficult problem and one in which two really valid objectives come into conflict.

Senator EVANS. Thank you, Senator.

Senator MITCHELL. I have no questions, Mr. Chairman.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. No questions.

The CHAIRMAN. Any other questions?

[No response.]

The CHAIRMAN. If not, Senator, we thank you very much.

Senator EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witness is the Honorable Margaret Heckler, the Secretary of Health and Human Services.

Welcome.

Secretary HECKLER. Thank you.

The CHAIRMAN. Good to have you with us this morning.

Secretary HECKLER. Thank you very much.

The CHAIRMAN. Go right ahead.

STATEMENT OF THE HONORABLE MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary HECKLER. Mr. Chairman, members of the committee, it's a great pleasure for me to be here this morning with you to discuss the administration's proposals for fiscal year 1986 which are under the jurisdiction of this committee.

Since you are preparing to take action on budget reconciliation, I will comment briefly on alternatives to our recommendations, including some of those advanced by your colleagues on the House side. We have serious concerns about many of the House provisions, which I will share with you in a moment.

I should note that all of the administration's legislative and regulatory proposals are summarized in my more lengthy statement for the record.

The most fiscally significant of the President's legislative proposals are laid out in three bills before this committee—S. 1550, the Health Care Financing Cost Reduction Amendments of 1985, introduced by Senator Durenberger on August 1 at the administration's request lays out our proposals in the health area; S. 1081, the Social Welfare Amendments of 1985, introduced by Senator Roth on May 7 provides the legislative language for implementing the President's proposals in the AFDC Program; Senator Armstrong has introduced S. 1266, the Foster Care Adoption Assistance Amendments of 1985.

In addition, we will soon transmit to Congress draft legislation to make administrative improvements in the Medicare and Medicaid Programs, and a draft voluntary voucher bill.

Since debate over the fiscal year 1986 budget began 8 months ago, we have all been united in our belief that the single greatest domestic problem facing the United States of America is the necessity of reducing the Federal deficit. It was true then; it remains true today. And I believe we are all equally united in our earnest dedication to work toward that objective.

Now the time is upon us and we must take firm action to make the final decisions that will reduce overall Federal spending and the Federal deficit.

At the Department of Health and Human Services, we were careful in crafting a budget that met the President's strong commitment to both restraining spending and meeting the basic needs of the poor, the handicapped, the ailing and the aged in our society. And these are commitments about which I feel strongly.

We have not waivered in our belief that the budget presented would fairly meet these goals in a logical and prudent way.

While the reconciliation instruction targets set in the budget resolution will guide your efforts, I want to remind you of how far removed these targets are from the savings proposed by the President in his fiscal year 1986 budget.

The President proposed program changes that would save $23.23 billion over the next 3 years for the programs under the committee's jurisdiction. With the compromises which led to the budget resolution, that amount was whittled down to $11.45 billion, barely half of what the President recommended.

The President has shown that savings significantly greater than $11.45 billion are possible. I urge you to follow his leadership. There will be no penalty for exceeding the targets in the measure you report.

And I know when you go into conference with your House colleagues it will not be easy or simple to draft a compromise that fully meets the targets.

When I last appeared before you in February 1984, we stood at the beginning of a new era. Through the Social Security amendments of 1983 signed into law by President Reagan in April of that year, we gave the Social Security Program the capacity to remain sound and put Medicare on sounder footing.

In February, 1984 the Social Security Trust Funds were just beginning to feel the rejuvenating effects of the 1983 amendments. Also promising was the ability of the prospective payment system to improve the status of the Hospital Insurance Trust Fund, which funds the hospital portion of the Medicare Program.

I would like to note here that, on this date, the news of the Hospital Insurance Trust Fund is, indeed, good. At the end of March, the other members of the Medicare Board of Trustees and I were able to report that—even under the most pessimistic assumptions—the Trust Fund would remain solvent through 1992. That is a full 3 years later than reported in 1984.

Let me get on to a discussion of the health proposals. First, I would like to address Medicare, Medicaid and the health system generally.

When this administration took office, Medicare and Medicaid costs were soaring off the charts—20 percent at one point. As you can see, this chart indicates the increase in growth in Federal health care costs before 1981, and then the dramatic drop in those costs.

Medicare, in particular, was in peril. A vicious cycle was at work. The exploding medical costs threatening Medicare were at least partly caused by the Medicare statute itself.

Now the trend has been reversed. Even more importantly, this had a profound impact on the entire medical care inflation rate. And this was achieved not by cutting benefits, not by reducing quality. With the vital partnership of this committee, we did it in the old-fashioned way. We worked at it, changing the system and its perverse incentives.

For years, the Federal Government had operated as a cost reimbursement provider of health care for millions of Americans. Now our objective is to make Uncle Sam a prudent shopper. I know that this is an objective which we share.

In about 2 weeks, the prospective payment system, which replaced the inflationary, open-ended, cost-based method of paying hospitals, will mark the start of its third year. I'm pleased to report to you that it has been enormously successful.

The length of stay is down to 7.7 days. And there is clear evidence that the use of costly ancillary services has decreased.

Moreover, our Peer Review Organizations [PRO's], under contract with the Health Care Financing and Administration to address specific concerns relating to the new system, report no systemwide problems to date. There is no evidence of any decrease in the quality of care, according to the information that we have received from the PRO's.

In my view, the careful consideration that Congress gave to the administration's new prospective payment plan in 1983 resulted in a difficult but creative decision which has brought about a revolutionary change that reversed the wrong incentives that had driven the behavior of hospitals earlier, since the time that the program for the elderly began.

Since then, the whole environment of hospitals and health care has been influenced. Change is in the air. Hospitals are seeking to improve service and efficiency. They are responding to the stimulus through innovation and through health promotion.

I see that the preliminary time has expired. I will just summarize some of these points if I might, Mr. Chairman, because I feel it's very important for the committee to take cognizance of the health gains that we have made.

As we move into this next period of transition, I am confident that the prospective payment system will continue to produce efficiency and yield quality results. And in this spirit, let us not diminish the gains that we have achieved. Let us stay the course.

This is the challenge before this committee. Frankly, your House colleagues have fallen prey to other temptations. The House Ways and Means Committee bill backs away from our earlier commitment to fully implement a national prospective payment system by the end of fiscal year 1986.

We strongly believe that prospective payment should move ahead on schedule. This belief is based on all of the data available in our Department. There is no justification for delaying the implementation of prospective payment. There is no evidence, no validation for that.

The administration opposes increasing hospital payments for fiscal year 1986, again, in light of solid evidence that there is no justification for that increase.

On the question of how to make special provisions for hospitals that serve a disproportionate share of patients who have low income, we continue to be very concerned. However, we must state that the data are very poor. As we search for better information, we find that under the existing data there is virtually no realistic way to determine the relationship between a hospital's Medicare costs and its proportion of low-income patients.

There are no known data on the incomes of patients residing in hospital beds. We are currently working to assemble a reliable data base upon which to create a valid model for the adjustments that need to be made in terms of disproportionate share.

We feel we have worked too long and too carefully in guaranteeing the integrity of the new reimbursement system to create a difference within the system that is not based on rational and equitable grounds.

We urge that you not automatically resist increases in beneficiary cost sharing. The current contributions by beneficiaries for part B premiums and deductibles lag far behind the financing proposals that the Congress intended when Medicare was actually enacted. We hope that you will consider favorably modest changes in these areas, such as those proposed by the administration.

We urge you to object to the Ways and Means' provision which would prohibit the Department from implementing the regulation limiting Medicare payments for graduate medical education. Today, the Public Health Service predicts a surplus of 35,000 physicians by the year 1990.

In light of the low general inflation rate and the surplus of physicians, we do not believe that increased hospital expenses for interns' and residents' salaries are necessary for the efficient delivery of health services. We believe that it is appropriate to limit these costs through regulation.

The CHAIRMAN. Let me ask you a question, if I can, because I do want to set you off, if I possibly can.

And the reason I say that is this: We went all through these proposals of the administration when we first started the budget process. I met with the Democrats and I met with the Republicans. And we know what they are. Some of them are going to pass; some of them aren't. And I think we know where the points of difference are, and I know these members want to ask you a lot of questions. And I would just as soon have you abbreviate the rest of your statement, because I don't think the positions are new; nor are the controversies new. But there are some things that we want to get at and we have got about 12 witnesses coming behind you.

Secretary **Heckler**. I would like to reflect on the changes relating to home health agencis, because I think this is an area in which there is a great deal of controversy in the committee, and also a very valid concern.

As you know, Mr. Chairman and members of the committee, between 1973 and 1982, Medicare expenditures for home health care reimbursement increased at an average annual rate of 31.5 percent.

In fiscal year 1986, home health care will represent over 3 percent of all Medicare expenditures, a doubling since 1975.

We are very committed to the continuation of home health care, Mr. Chairman. We feel very strongly that it is a very necessary dimension to the Medicare reimbursement program.

However, under our prior regulations home health care reimbursement was subject to limit is set at the 75th percentile of average cost per visit incurred by all home health agencies. Although separate limits are established for each type of service, the limits are applied in aggregate depending on the mix of services at each home health agency. Thus, the system allowed agencies to offset high-cost services with low-cost services. And as a result, this fast-growing component has not had an incentive to provide efficiency within the delivery of its services.

The interesting comparison is that payments for many of the home health services for a single visit are on par with what Medicare pays for 24-hour care in a skilled nursing facility. For example, the urban per visit limit for skilled nursing facility visit is $53.41. The average daily limit for a skilled nursing facility is $60, which covers the cost of room, board, laundry and 24-hour nursing care.

The new limits published by HCFA say that Medicare will pay 120 percent of the mean cost of services applied in each discipline. Quite simply, home health agencies will not be able to aggregate their costs under this new regulation.

We feel that this is a change which will produce greater efficiency of management by the home health agencies. At the same time, under our calculations, the reimbursement for home health agencies will expand this year by over $300 million, so we are not curtailing home health services.

Obviously, there are many other points that can be made here. Mr. Chairman, but in the interest of allowing time to respond to questions, I would be glad to finish here.

The **Chairman**. Thank you.

[The prepared written statement of Secretary Heckler follows:]

STATEMENT OF

THE HONORABLE MARGARET M. HECKLER

SECRETARY OF HEALTH AND HUMAN SERVICES

Mr. Chairman, Members of the Committee:

It is a distinct pleasure to appear before you today to discuss the Administration's proposals for Fiscal Year 1986 which you will be considering shortly as you respond to the reconciliation instructions of the First Concurrent Resolution on the Budget for Fiscal Year 1986. I will also comment on alternatives to the Administration's proposals including some of those advanced by your House colleagues on the Ways and Means and Energy and Commerce Committees in response to their reconciliation instructions.

The most fiscally significant of the President's proposals are laid out in three bills before this Committee. S. 1550, the "Health Care Financing Cost Reduction Amendments of 1985," introduced by Sen. Durenberger on August 1 at the Administration's request, lays out our proposals in the health care financing area. S. 1081, the "Social Welfare Amendments of 1985," introduced by Sen. Roth on May 7, provides the legislative language for implementing the President's proposals in the AFDC program. Sen. Armstrong has introduced S. 1266, the "Foster Care and Adoption Assistance Amendments of 1985."

The functional totals of the Congressional budget resolution only assume savings in the health area. If meaningful deficit reduction is to occur, the budget resolution's reconciliation instructions must be considered a floor, not a ceiling. Some will say that because the budget resolution assumes no savings in the human services area, the Committee should make no changes. I urge you to reject this thinking and consider all our proposals on their merits.

While the reconciliation instruction targets set in the budget resolution will guide your efforts, I want to remind you of how far removed those targets are from the savings proposed by the President in his budget. For FY 1986, we proposed program changes that would save $23.2 billion over the next three years within the programs under this Committee's jurisdiction. Through the compromises which led to the budget resolution, that amount was whittled down to $11.3 billion, not even one half of what the President proposed.

The budget deficit remains the single largest domestic problem facing the Federal Government. The President has shown that savings significantly greater than $11.45 billion are possible. I urge you to follow his leadership. There will be no penalty for exceeding the targets in the measure you report. And I know when you go into conference with your House colleagues it will not be easy or simple to craft a compromise that fully meets the targets.

When I last appeared before you, in February of 1984, we stood at the beginning of a new era. Through the Social Security Amendments of 1983, signed into law by President Reagan in April of that year, we gave the Social

Security program the capacity to remain sound and put Medicare on a much stronger footing. The Social Security trust funds were just beginning to feel the rejuvenating effects of the 1983 amendments. We were just beginning to see the ability of the Prospective Payment System to improve the status of the Hospital Insurance (HI) Trust Fund which funds the hospital portion of the Medicare program.

We have continued to feel the salubrious effects of the 1983 amendments. Earlier this year the Old Age and Survivors Trust Fund repaid $4.4 billion it was forced to borrow from the Hospital and Disability Insurance Trust Funds. Also heartening is the state of the Hospital Insurance Trust Fund. At the end of March, the other members of the Board of Trustees of the HI Fund and I were able to report that even under pessimistic assumptions the Trust Fund would remain solvent through 1992. This is a full three years later than we reported in 1984.

But this has not diminished the challenge before us. Although we have made impressive gains in the HI Trust Fund's actuarial status, our society can not afford the costs as the population ages and Medicare bears an ever increasing share of the 10.6% of our GNP spent on health care.

Under the President's proposal, Medicare expenditures on behalf of the elderly and disabled will continue to increase. Medicare expenditures would increase from $71.4 billion to $73.2 billion. CBO has estimated that without the reforms the President has proposed, the Medicare program would incur $18 billion more in costs over the next three years than it would if the President's proposals were implemented.

While we can be pleased with the knowledge that the Hospital Insurance Trust Fund is on the right track, we should be troubled by our lack of progress in the Supplemental Medical Insurance (SMI) Trust Fund which derives 75% of its funding from the general funds in the Treasury. Even with the economies achieved by last year's Deficit Reduction Act, the general fund contributions to the SMI Trust Fund, which pays Medicare part B costs, continue to increase at a much faster rate than domestic spending as a whole.

Our budget request for grants to States for Medicaid represents an all-time high. In FY 86, it would amount to $23.69 billion, up from $22.81 billion. We are proposing to limit growth in State Medicaid spending by decreasing the rate of growth, and our proposal would save $1.3 billion.

States are currently able to decrease the rate of growth of Federal matching expenditures, while accruing savings to both State and Federal governments. In FYs 1981 through 1984, States held Federal Medicaid outlays to 5% annual growth. This resulted in significant savings for the Federal and State governments. The Administration's proposal would permit an average 5.7% annual rate of growth from FY 86-90. This is a comfortable margin above the 5% annual growth seen in FYs 1981 through 1984. Indeed, within a 5% growth rate States have had the resources to fund optional Medicaid services and coverage which exceed Federal requirements.

To help States control costs, burdensome Federal requirements would be eliminated or reduced. Under the proposal to constrain increases to reasonable growth levels, States would receive increased program flexibility. These cost controls, coupled with easing of Federal requirements, will aid the States in preventing Medicaid program cost growth from consuming an ever increasing share of their — and the Federal — budgets.

The challenge to preserve the gains we have achieved is made ever more difficult by attempts to compromise commitments and to slip program expansions into packages which say they reduce the deficit. Your House colleagues have have fallen prey to these temptations. The House bills, for example, include significant expansions of the AFDC and Medicaid populations, a new, expensive, and duplicative teen pregnancy program, and an expansion of the coverage of optometrists' and occupational therapists' services under Medicare Part B. It is a Trojan horse they want to send you, Mr. Chairman, and I urge you to be wary of it.

In summary, the Administration has recommended a balanced package of spending reductions which, if adopted, would exceed the Committee's target. We oppose the adoption of proposals which would add to the Federal deficit. We urge the Committee, at a minimum, to reduce Medicare and Medicaid outlays at least by the reconciliation instruction of $11.3 billion which can be achieved without adversely affecting either the quality of health care or beneficiary well-being. We also ask that you reject "savings" which would be achieved through increases in revenue.

I would like now to focus on human services issues. Before addressing spedific legislative proposals, I want to note the importance of the Administration's economic policies to the work of the Department. Last month's poverty data demonstrate that the economic recovery is dramatically reducing the level of poverty in this country. Perhaps more importantly, the creation of new economic opportunities has fostered a much-needed sense of optimism and self-reliance among millions of low-income Americans. It is no accident that the young, who have the most to gain from new opportunity, have been the strongest supporters of the President's policies.

This Administration's human services policies are building upon the strong foundation of the economic recovery by opening doors for millions of deserving Americans. Our policies are also promoting public faith in government by demonstrating an unwavering resolve to eliminate waste. Our commitment to quality control has saved the taxpayer billions of dollars.

Our human services proposals for this year both save money and promote important values. With our foster care proposal, we strive to give all children the opportunity to live with families that will love and nurture them. With our AFDC work opportunities program, we strive to promote self-reliance and dignity. Efficiency and opportunity are the cornerstones of both our successful economic policy and our successful human service policy.

The achievements of this Administration are impressive: a decline in the overall rate of inflation from 12.6 percent to under 4 percent, inflation in the health field falling below 10 percent for the first time in recent memory. But the accomplishments they have aided, significant improvements in the health of the Social Security and Medicare trust funds, are still not secure. Their cost is continued vigilance, a task, Mr. Chairman, that falls on your your Committee as it seeks to meet its reconciliation targets.

I will now describe in detail our proposals and comment on alternatives, beginning in the health area and then continuing on to human services.

MEDICARE PROPOSALS

Prospective Payment Rates

On September 3, the Department promulgated Final Regulations implementing the third year of operation of the prospective payment system. This rule modifies the system to incorporate changes and improvements arising from our experience over these past two years. Overall, we are confident that these refinements will further our original objectives to:

- restructure hospitals' economic incentives;
- base payment on a system that identifies the product being purchased more accurately than a cost reimbursement system does;
- reinforce the role of the Federal government as a prudent buyer of services; and
- restrain the rate of hospital cost increase, thus moderating the outflow of expenditures from the Medicare trust fund.

One of our foremost concerns in developing this rule was the proper level of payments. As you are aware, we are required by law to consider a number of factors, including: the hospital market basket index; hospital productivity; technological and scientific advances; quality of care; case-mix data; and the recommendations of the Prospective Payment Commission. In addition, we believed it only logical to consider prior years' experience as well.

By the end of 1984, we realized that, despite our best efforts to achieve budget neutrality (as required in the first two years of PPS), the rates for FY 1985 were too high. As a result, in preparing the President's Budget, we assumed that the FY 1986 payment rates would be maintained at the 1985 level. At that time, we did not realize that later data and experience would show that we would be justified --legally and technically --in a 4.42 percent reduction in the rates. Taking into account the combined effect of case mix increases, market basket forecasting error, inaccurate cost-per-case assumptions, and the consequences of using unaudited cost data as a basis for rate-setting, the current rates are probably overstated by at least 8.5 percent. (A detailed discussion is included in the June 10 Notice of Proposed Rule Making.)

Establishing FY 1986 rates based on FY 1985 rates that have been demonstrated to be overstated clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care.

I would note that, while justification exists for lowering the payment rates, we elected not to do so. The unintended consequences could disrupt the industry and have an impact on the access to quality care that our Medicare beneficiaries rightfully expect.

For the above reasons, the Administration believes an increase in the payment rate, as approved by the Ways and Means Committee, is not warranted, and we oppose it.

We strongly oppose the Ways and Means provision which would delay by one year the transition to a fully national prospective payment system. The positive results of this new system and its objectives at inception --which I have outlined above --convince us that the transition should continue on schedule. In addition, a delay in that schedule could be interpreted as an indication of a lack of confidence in the system, thereby undermining the spirit of cooperation and State and private sector efforts which have facilitated its implementation. Moreover, hospitals with historically higher costs would continue to receive higher payments at the expense of those hospitals which all along have provided care in a more efficient, less costly manner.

I should like to emphasize here that we enter this, our final transition year, with a two-year track record behind us:

o significant reductions in length of stay have moderated the amount of resources needed to provide routine care;

o the number of Medicare admissions to hospitals is also declining -- consistent with the trend overall;

o there is evidence that use of costly ancillary services is decreasing;

o cost-effective ways of providing "high-tech" procedures are in evidence.

I am extremely encouraged by the results to date. The hospitals of America have met the challenge; they have shown insight, imagination and initiative. Indeed, those hospitals which have responded positively to the incentives of the prospective payment system have prospered since the new system went into operation.

Let me emphasize here that this Department remains committed to quality assurance and access to care. Most importantly, not only are the economic goals of the system being met, but various monitoring efforts, both public and private, indicate that beneficiaries are continuing to receive good quality care:

- The Peer Review Organizations initiated by this Committee and fiscal intermediaries and consumers are responsible for evaluating whether the quality of services meets professionally recognized standards of care;
- The Department assures hospital compliance with health and safety requirements through surveys and inspections; and
- State health departments enforce professional licensure requirements aimed at reducing health care risks.

We believe the growth in health care expenditures can be restrained without harming patients, and we feel there are proper safe-guards in place to protect our beneficiaries.

Medical Education Costs

On July 5, we promulgated another significant rule, the substance of which was reflected in the President's Budget. The Department is imposing a one-year limit on the amount Medicare will pay hospitals for their direct costs related to medical education activities. As you are aware, these payments are in addition to the amount hospitals receive under the prospective payment system. As Administration witnesses have testified before this Committee, it is our view that after 20 years of program experience, States and localities, medical schools, and private philanthropic groups should assume more responsibility for the costs of medical education. Our view is consistent with the original intent of Congress in 1966 when the direct medical education payment was seen as a temporary subsidy.

I know that several Members of this Committee share our view that action must be taken to limit the current open-ended funding of medical education from the Medicare trust fund. We note particularly S. 1158, sponsored by Senators Dole, Durenberger and Bentsen, which would also freeze payments for one year.

Restricting what we will pay for medical education should provide an incentive for the medical education community to examine its priorities and begin to shape its residencies to conform to today's -- and tomorrow's -- health care market place.

We urge you to reject amendments such as the House Ways and Means provision which would prohibit the Department from implementing this regulation. This action would increase Medicare outlays by $125 million in FY 1986. The Department also opposes the House Energy and Commerce provision, a very limited and meaningless effort, aimed only at Medicaid costs.

Indirect Teaching Adjustment

Medicare is also paying more than its share for the indirect teaching costs. In Fiscal Year 1986 --assuming no change in policy --we estimate that Medicare expenditures for these costs will be $1.4 billion. As you are aware, in developing the prospective payment legislation, Congress elected to double the factor used in calculating the formula for computing this adjustment. This add-on, which is now 11.59 percent, has produced an unintended bonanza by providing a 100 percent windfall over the analytically derived estimate of of 5.79 percent.

- To illustrate, a heavy teaching hospital can receive a higher Medicare payment per admission for a hernia requiring six days of care than a non-teaching hospital receives for a hip fracture requiring twice as as many days of care.

	Hernia	Hip Fracture
-- Non-teaching hospital	$2,764	$4,092
-- Teaching hospital	$4,656	$6,938

In our Health Care Financing Cost Reduction Amendments of 1985 (S. 1550), we propose to eliminate the doubling of the indirect teaching adjustment. It should be noted that, under our proposal, Medicare would still make an additional payment for indirect medical education costs in teaching hospitals. Medicare would still recognize the difference in costs between teaching and non-teaching hospitals. It would no longer, however, recognize double that difference. This proposal would save $695 million in FY 1986.

While Ways and Means has approved a reduction of about one-fourth in the adjustment factor, that bill does not go far enough in eliminating the windfall.

Disproportionate Share

Ways and Means has also approved giving extra payments for urban hospitals serving a disproportionate share of low-income patients. We oppose this provision. While this issue is of great concern to the Administration, we believe that such an adjustment is premature at this time. The relationship between Medicare costs and low-income patients is still not well understood.

We do, however, have a research effort underway which should enable us to construct a better proxy than is currently available. In the meantime, arbitrarily selecting a definition of a "disproportionate" share hospital and rewarding only those hospitals which fit that definition would only create a whole new set of winners and losers.

Physician Fee Freeze

In the Administration's bill, S. 1550, we propose to extend the existing freeze on physicians' fees for an additional year. I should like to note here that the physician fee freeze enacted last year has provided additional protection to Medicare beneficiaries and reduced the rate of growth for Medicare expenditures for physicians' services. Beneficiaries have been favorably affected by the freeze in several ways: reduced coinsurance, lower premiums, and reduced extra billing that would have occurred if fees were permitted to increase. In addition, over two-thirds of Medicare claims for physicians' services are now paid under assignment.

Last Spring's deficit reduction agreement between the White House and the Senate Leadership, which proposed to save $200 million under Medicare, assumed a modified physician fee freeze proposal. There are a number of options for such a proposal, and we will be happy to work with you to develop alternatives in the context of achieving an overall part B savings goal. We would note that we oppose any physician fee freeze that mandates assignment.

Home Health Reforms

The Department has recently revised the methodology used in setting limits on home health agency (HHA) costs that may be reimbursed by Medicare. On July 5, we promulgated regulations implementing these new limits.

The most significant changes to the former methodology limits are:

- setting the limits at 120 percent of mean cost for services rather than at the 75th percentile, and

- they are applied by discipline — or type of visit, instead of in the aggregate.

We believe that it is necessary to provide high-cost home health agencies with increased incentives to bring their expenditures into line with those of the more efficient providers of service. We fully expect that home health agencies' behavior will change as a result of these refinements, both in terms of management and cost reporting. In general, an agency will be motivated to ensure that each type of service it furnishes is delivered efficiently and in a cost-effective manner. We expect that the need now to accurately classify their costs by function will lead to closer scrutiny of salaries, staffing levels, staff productivity and administrative costs.

It should be noted that a change to application of the limits by discipline fulfills the intent of Congress in the Omnibus Budget Reconciliation Act (OBRA), P.L. 97-35. The Conference Committee Report accompanying the legislation urged the Secretary, as soon as feasible, to implement this change.

By definition, setting the limit at 120% of the mean methodology results in limits for a discipline that are set well above the average costs, based on the actual reported costs of a substantial proportion of participating HHAs. Given the data available to us, we do not think the current range in per visit costs is justified. Thus, we are setting the proposed limits at 20 percent above mean cost per visit. Most HHAs with costs in excess of the limit can reduce their excess costs through more efficient administration, with no effect on either the quality or availability of services. An interesting comparison here is that payments for many of the home health services for a single visit are on a par with what Medicare pays for 24-hour care in a skilled nursing facility. For example:

- o the cost limit for a skilled nursing care home health visit is $53.41;
- o an average daily limit in a skilled nursing facility is $60, and covers the cost of the room, the meals, laundry and 24-hour nursing care.

Mr. Chairman, we urge that the Committee reject any attempts to prevent the Department from implementing these regulations.

Home Health Co-Payments

Payments under the home health benefit have expanded greatly since the Omnibus Reconciliation Act of 1980, which eliminated any beneficiary cost-sharing.

Previously, from 1978 to 1980, the number of home health visits per beneficiary increased between 7 and 12 percent. After the 1980 amendments, the rate of increase went to 14% in 1981 and 16% in 1982. Expenditures for home health have grown an average of 19% annually. Our proposal would impose a modest co-payment of one percent of the inpatient deductible (estimated to be $4.80 in 1986) for visits after the 20th visit. Since the average user of home health services receives 25 visits, he or she would be liable for payments of about $24 in 1986.

Part B Premium and Deductible

Our proposals regarding beneficiary costs for part B are nothing more than a reassertion of the principles contained in the original legislation signed into law by President Johnson twenty years ago. The program signed into law called for beneficiaries to bear half the cost of the part B program; the Administration has only asked that beneficiaries bear 35% of program costs.

Under current law the premium is slated to go up only 30 cents in 1986, from $15.50 to 15.80. This is the smallest increase since 1976. With respect to the deductible, the original Medicare law said that part B beneficiaries paid the first $50 of covered services each year. In today's dollars, that would be $150. The Administration has proposed to index the deductible beginning in FY 87 which would increase it to $78, only a $3 dollar increase over the current level, still leaving us far behind the Johnson-era level. We have only proposed that we not fall any further behind.

Both our proposals to increase the premium share of program cost and index the deductible will leave the beneficiary better off than he or she was in 1966 when Medicare began and lessen Medicare's burden on the Treasury.

Working Aged

The Tax Equity and Fiscal Responsibility Act of 1982 made Medicare the secondary payor for beneficiaries age 65-69 who work and are covered under employer-based health insurance. Last year this was extended to cover beneficiaries aged 65-69 covered by a working spouse's employer health plan. We have looked at the situation and see no rationale for drawing the line at 69. Thus we have proposed to do away with any age line. Of course, the beneficiary retains the option of being covered only by Medicare. Over the next five years this proposal would save $2,470 million. We are pleased to see that your colleagues on the Ways and Means and Energy and Commerce Committee have proposed enacting this provision.

Eligibility

In the eligibility area we are also proposing changing the date on which Medicare eligibility begins, currently the first day of the month in which an individual attains age 65. We propose instead to begin eligibility on the first day of the first full month in which a beneficiary is age 65. We see no negative impact from this provision since nearly all employer-based group health plans extend coverage to the date Medicare coverage begins. Like the proposal on the working aged accepted by the House Committees, the savings to the Medicare program would not affect beneficiaries. Savings from the change in start of eligibility would amount to $1,625 million over the next five years.

One-Year Freeze on Payments to Clinical Laboratories

Under pre-DEFRA Medicare reimbursement rules, it was widely believed that clinical laboratories were overpaid. Comparable Canadian experience suggests that current Medicare lab fee schedules are still excessive. Thus we believe it is reasonable to extend our freeze policy for other providers. We oppose provisions that would increase spending above the freeze level or that would mandate assignment.

Limits on Purchase and Rental of Durable Medical Equipment (DME)

The current charge system for DME and other part B services is inherently inflationary since it bases future Medicare payments on current actual charges. In a notice to be finalized this month we are freezing payments for DME and other part B services for one year and establishing a fee screen thereafter. We oppose any legislative action that would increase Medicare program costs over the freeze level or which would mandate assignment.

Issues Remaining from Cost-Based Reimbursement

Prior to the prospective payment system (PPS), as we know all too well, Medicare paid hospitals on the basis of reasonable cost. In general Medicare paid for its share of a hospital's cost in proportion to Medicare beneficiaries' utilization of a hospital's resources, generally measured as the ratio of Medicare charges to total charges or the ratio of Medicare days to total days. In the area of malpractice, as a result of 1979 regulations, Medicare paid, and still pays PPS-exempt facilities, according to the incidence of malpractice claims our beneficiaries generated. In facilities where our beneficiaries caused no losses, we did not pay for malpractice costs. Paying in proportion to total use meant Medicare paid its fair share for the nursing services and clean sheets our beneficiaries used. But this is not the case for malpractice costs. Our beneficiaries, the aged, disabled, and retired, have lower life expectancy and income potential than the population at large.

Now, as we enter the third year of the prospective payment system, we are faced with continued litigation on this question by hospitals who are using their lawyers to get a few last cookies out of the now-antique reasonable cost cookie jar. We do not believe that the Congress intended for Medicare to pay for costs our beneficiaries played no part in creating. Thus we are asking that you make explicit in the law the Medicare should only pay its fair share by separate accumulation and direct apportionment on a claims paid basis of malpractice related costs.

We are experiencing a similar challenge, also a relic of the days of cost-based reimbursement, relating to the counting of labor and delivery room days towards the calculation of total number of inpatient days. Since 1976 Medicare has had the policy of including labor and delivery room days as part of total inpatient days. Some providers argue that this drives down the cost per day, and have fought their inclusion. But they overlook the fact that maternity and pediatric routine patients, few of whom are Medicare beneficiaries, incur higher per diem costs than most other routine patients. We believe that our policy here, as in so many of the complex issues posed by cost-based reimbursement, provided a fair and reasonable solution to the problem.

What would be unfair in both of these cases would be for the HI Trust Fund to incur what could amount to several hundred million dollars of expenses providing lump sum payments caused by re-calculating payments made in fiscal years long past. Thus we urge you to include language in your reconciliation bill to clarify that Medicare's policy was consistent with the intent of Congress.

Voucher Proposal

Finally, Mr. Chairman, I would like to mention that we will soon transmit to the Congress draft legislation which would build on the HMO provisions in TEFRA. The voluntary voucher proposal would expand the pool of plans that qualify for capitation payments. We would be pleased to discuss this proposal in detail with the Committee at the appropriate time.

MEDICAID PROPOSALS

Turning to the Medicaid program, our proposals build on measures enacted in 1981 to constrain expenditures and permit innovation to improve the use of limited health resources. States have the ability to control costs and when they do, savings accrue to both State and local governments.

The annual growth in Medicaid expenditures declined from 15 percent for the period 1976-1980 to 10.1 percent for 1980-1984. The growth rate was only 5.8 percent between 1983-1984, well below the 9 percent growth rate in total national health expenditures for the same year. This dramatic change can be attributed partly to reductions in OBRA-mandated Federal Medicaid matching payments, which expired at the end of FY 1984.

For example, in 1981, States began to implement new prospective hospital reimbursement methods that significantly improved hospital efficiency, thus reducing Medicaid costs. To date, 26 States have instituted these new methodologies. Between 1980 and 1984, the rise in outlays for hospital inpatient services declined from 12.2 percent to 1.6 percent. States have also taken advantage of provisions permitting greater administrative flexibility to shift the emphasis of the program away from more costly institutional care and to redirect recipients to more efficient, cost-effective providers of service.

The failure to reintroduce any direct constraints on Federal costs at this time could add significantly to the Federal budget deficit.

Medicaid Cap

We propose capping Federal Medicaid payments to States at $23.7 billion in FY 1986. This would replace the present open-ended system and would provide incentives to States to adopt further cost-containment measures, reduce fraud and abuse, and increase third-party liability collections. For FY 1987 and beyond, the Federal Medicaid expenditure's cap would be indexed to the Medical Care Component of the Consumer Price Index.

Our proposal includes a one-time $300 million "hardship" funding pool which would be established in FY 1986 to facilitate the transition to the limit on Federal payments.

We believe this funding arrangment would stimulate States to continue to establish cost effective and efficient reform in program administration.

The States are in the best position to decide how their programs should be economically designed and efficiently operated to benefit people in need. We have proposed, in conjunction with the payment cap, proposals which would allow States a freer hand to decide which groups may be covered, what services they receive, and how much their providers are paid. Removing cumbersome Federal requirements would allow States to target limited Medicaid dollars to suit the needs of their own particular population.

Fixed Grants for Administration

Grants to States for Medical assistance do not account for all Federal expenditures related to Medicaid. In the current fiscal year we expect to pay $1.2 billion to States as grants for Medicaid administrative costs. As with actual assistance costs, we are asking States to take on greater responsibility to control costs. For fiscal year 1986 we propose freezing grants for administration at the FY 1985 level. For subsequent fiscal years we would increase the amounts available by the change in the GNP deflator. Thus States will know in advance what amount of resources for administration will be available from the Federal government and can plan accordingly.

Medicaid Eligibility Expansion

Senator Durenberger's and Senator Bentsen's bill S. 505, The Maternal and Child Health Preventive Care Amendments of 1985, would permit States to target certain services to all Medicaid-eligible pregnant women without being required to provide these same services to other Medicaid eligibles, as is now the case. It would permit continued Medicaid coverage for pregnant women who would lose their Medicaid coverage upon the end of their pregnancy. As I indicated earlier, a deficit reduction bill is not the appropriate vehicle for program expansions. We are concerned that our mutual goal of reducing spending would be severely impeded if this principle is breached. We therefore oppose including these provisions in a reconciliation bill.

In addition, we strongly oppose the House Energy and Commerce bill which mandates Medicaid program expansions. This would add $465 million to the budget deficit.

Third-Party Liability Initiative

We want to acknowledge the Finance Committee's initiative in seeking to increase third-party liability payments. We estimate that 10 to 15 percent of Medicaid recipients have private health insurance coverage. We support the direction of your proposal, but we believe it may be difficult to actually achieve the projected savings. The Statement of the Managers accompanying the Conference Report on the First Conconcurrent Budget Resolution also indicated that failure on the part of the States to achieve the projected third-party liability savings may not be enforced against them. A systematic approach is needed to implement the statutory requirement mandating Medicaid as last-dollar payor and to realize third-party liability savings. We would be happy to work with your staff to achieve these savings for Federal and State treasuries. Our joint efforts should help us tap an important area of savings that has been underutilized up to this point.

Increases in Expenditures

Finally, Mr. Chairman, we have noted our objections in principle to including in a deficit reduction bill provisions that increase spending. The House bills contain several such provisions. In addition to the one mentioned earlier:

- o we oppose the provision in the Energy and Commerce bill which would expand the types of services optometrists may perform under Medicare;
- o we oppose the Ways and Means provision which would extend part B Medicare payments to cover occupational therapy services in a variety of outpatient settings.

MATERNAL AND CHILD HEALTH

We are also proposing a minor change to the Maternal and Child Health (MCH) Block Grant authority. As you know, this block grant program provides over $400 million per year to the States to support a broad range of health services, including preventive, primary care, and rehabilitative services. It is a principle source of support to States for their leadership in planning, promoting and coordinating health care for mothers and children who otherwise would not have access to adequate care.

Our proposed amendment would allow States to expend those funds over a longer period of time than the law currently permits. Specifically, our proposal would repeal a provision which requires the money to be spent within two years of its allotment. The removal of this restriction would make the MCH block grant legislation consistent with other block grant authorities. More importantly, it would provide the States with the flexibility to plan and effectively support long-range programs. It is our expectation that this amendment would result in more effective health services being provided to the mothers and children served by this program.

SOCIAL SECURITY

I would like to make a few comments on Social Security matters raised by the President's budget and the Senate budget resolution.

The President's budget contains a proposal to have State and local government employers deposit Social Security contributions for their covered employees on the same deposit schedule that private employers must follow. States would deposit their social security contributions on the same schedule they now deposit tax withholding. In addition States would no longer be liable for deposits of substate entities. On June 20, 1985, the Treasury Department submitted to the Congress for its consideration a draft bill which would implement this proposal. This draft bill would bring about consistent treatment of public and private employers in terms of Social Security contribution deposit requirements and eliminate their financial drain on the Social Security Trust Funds caused by the present delayed State deposit schedule. The proposal would increase Trust Fund receipts of interest and State contributions by more than $2.5 billion over the next five fiscal years.

Another proposal contained in the President's budget would extend Social Security coverage to railroad employment beginning in 1986. Social Security benefits would be paid to railroad workers and their dependents and survivors who become eligible for benefits after 1985. At present, railroad workers pay tier I railroad taxes, which are the same as Social Security taxes, and receive tier I railroad retirement benefits, which are similar to Social Security benefits. This proposal, which would implement a recommendation of the President's Private Sector Survey on Cost Control, would end the anomaly of independent coverage of railroad employment under a program specifically intended to mirror the Social Security program. Railroad workers (and their dependents and survivors) becoming eligible for benefits in the future would not receive benefits that are less than if they became eligible for Tier I benefits today. In addition, some individuals who do not now receive benefits from railroad retirement would be eligible for Social Security benefits. Moreover, the inconsistencies and problems of coordination that arise from having two agencies administering Social Security coverage would be eliminated, and retired railroad workers and their families could seek assistance at any of over 1300 Social Security offices instead of under 100 railroad retirement offices.

I also want to take this opportunity to express support for H.R. 2005, the Social Security Minor and Technical Changes Act of 1985, which was passed by the House of Representatives on May 14, 1985 and has been referred to the Senate Committee on Finance for consideration. However, we do not support section 13 of H.R. 2005, which would reinstate Medicaid eligibility for widows and widowers who were disqualified due to the increase in benefits under section 134 of the Social Security Amendments of 1983. While we understand the concern that prompted this provision, there are a number of other factors that must be taken into account in considering the proposed amendment:

- ° Widows and widowers affected by the 1983 provision:
  - -- may already be eligible for Medicaid because they live in States that cover medically needy aged, blind and disabled persons not eligible for SSI and

-- generally already have Medicare coverage or will have it by the end of this year.

- Further, the proposal raises questions of equity because it provides special treatment for a closed group of individuals who were affected by the 1983 Social Security Amendments and does not provide similar Medicaid benefits for other persons in like financial circumstances.
- And finally, the proposal may also present some administrative problems because the group affected will be difficult to identify, and a special rule will have to be applied to them over the years.

We would suggest that section 2 of the bill be amended to provide that the authority included in section 505 of the 1980 disability amendments to conduct experiments and demonstration projects under title II be permanently established, rather than extended for only 5 years.

I appreciate your consideration of these issues.

HUMAN DEVELOPMENT SERVICES - FOSTER CARE

As the members of this Committee know, five years ago the Congress enacted the Adoption Assistance and Child Welfare Act of 1980, which restructured the Federal role and participation in programs for child welfare and foster care, and created a new role in adoption assistance. The new provisions -- under titles IV-B and IV-E of the Social Security Act -- focused on the need to actively track and plan for children in foster care, and make permanent placement in a family the basic goal for all children.

Five years later these new programs are well underway. There has been a significant decrease in the number of children in foster care; the length of time that children stay in foster care has decreased; and States have made significant progress in permanency planning. We can all take great pride in this achievement.

In this context, the Administration's proposals do not represent suggestions for massive change or significant restructuring of these programs. Our proposals, contained in S. 1266 introduced by Senator Armstrong, constitute a series of modifications intended to fine-tune the program and address specific problem areas, while retaining the basic structure.

First, our proposal would create a program of incentive payments to reward States that reduce the number of children who have been in Federally financed foster care for more than 24 months. The proposal recognizes that children who have been in foster care for more than 24 months are among the most difficult to help. After this length of time, reunification with the original family is less feasible, and adoption for older children becomes more difficult.

States that in any of fiscal years 1988, 1989 or 1990 reduce by at least three percent below the prior year's total the number of children in federally financed foster care more than 24 months will receive payments of $3000 per child for these reductions.

States could use this bonus payment money for any purpose under Title IV-E (foster care and adoption assistance), Title IV-B (child welfare services), or Title XX (Social Services Block Grant). We believe that States can use this flexible services money to strengthen their child welfare programs under any of these funding authorities.

I want to emphasize here that we regard this as a positive incentive. States that are unable to make reductions in the numbers of this group of children, or are unable to make the threshold three percent reductions, would not be penalized.

Several special interest groups have opposed this provision on the grounds that the vast majority of children in long-term foster care cannot be permanently placed. I reject that proposition as emphatically as I can. All across this country, individuals and families are willing to open their hearts and homes to children with special needs. Too many of these children languish in foster care because people have given up on them. When States utilize aggessive, creative placement programs, they have invariably found that there is a permanent stable family for every child.

Second, we have proposed two changes in regard to Medicaid eligibility for children under the Adoption Assistance program. Since many "special needs" children need the support of extensive medical services, children who are adopted under the title IV-E Adoption Assistance program are deemed eligible for medical assistance under Medicaid.

However, where adoptive parents move their family to a new State, they may not be able to find medical providers willing to accept an out-of-state Medicaid card. The uncertainty of continued Medicaid coverage if the family were to move may prohibit or discourage some families from adopting special needs children. It certainly causes difficulties for families led to expect continued medical support.

We are therefore proposing that children for whom a Title IV-E adoption assistance agreement is in effect be eligible for Medicaid in the State where they reside. We believe that this clarification of Medicaid eligibility will assure that medical services continue to be available to those IV-E children who need them.

A related proposal will eliminate the requirement that an adoption assistance payment must be made in order to assure a child's Medicaid eligibility. This change would eliminate the need for States to make token monthly payments of as little as $1.00 to maintain Medicaid eligibility for a child in those cases where parents do not need subsidy payments but do need support for medical services.

Third, we are also asking the Congress to make permanent the provisions of title IV-E which authorize Federal matching of foster care maintenance payments made on behalf of certain children voluntarily placed in foster care.

This was a temporary provision in the 1980 law to respond to concerns that in the case of a voluntary request of a parent for a child's placement, unnecessary court proceedings place additional stress on the family and could cause unnecessary trauma for the child. The provision was made temporary, however, based on concerns as to whether voluntary placement provided sufficient protection for these children.

In the results of a recent study of State use of voluntary foster care, we found that both voluntary and court-ordered placements received similar types and amounts of case planning and social services attention from the agencies involved. Consequently, the study concluded that the use of the court system is not required to assure that services are delivered to those in voluntary placement. Further, the use of voluntary foster care allows some States to provide temporary foster care and reduce the use of unnecessary and costly court procedures when a voluntary agreement would suffice.

Fourth, we are also proposing modifications to the allocation of funds under the title IV-E foster care program, including making the conditional limitations on foster care funding effective for any fiscal year in which at least $200 million is appropriated under title IV-B (Child Welfare Services); modifying the "indexing" provision to the lower of five percent or the Consumer Price Index annually; and changing the base year from 1978 to 1984 for purposes of calculating States' allotments.

Costs for the title IV-E foster care program are rapidly increasing, and the most rapidly increasing segment of program costs are the claims for administrative costs. While Federal expenditures for maintenance payments for foster care children have remained relatively steady, Federal payments for State administrative costs have multiplied more than four and one-half times, from about 10 percent of Federal payments in 1981 to one-third of Federal payments in 1984.

Nineteen States increased their administrative costs from 1981 to 1984 by over 500 percent and 12 States by over 1000 percent. In Fiscal Year 1984, five States spent more on administrative costs than they disbursed as payments on behalf of children in foster care. An additional 12 States had administrative costs which were between 50 percent and 100 percent of payments.

While we want to continue necessary funding for these important programs for children, we also believe there must be some effort made to reduce the rapid increase in costs, especially when the most rapidly increasing costs are not those involving direct payments for foster care maintenance. In addition, the provisions in the current law for distribution of funding and indexing of costs were created in response to 1978 conditions, and should be updated.

State foster care programs have matured considerably since 1978. We believe States are making significant progress in providing preventive services and improving the permanent placement of children, and will be able to control costs for this program while continuing to provide services to children in need of care.

HDS - SOCIAL SERVICES BLOCK GRANT

The Social Services Block Grant (SSBG) -- created by Congress in 1981 under title XX of the Social Security Act -- provides funds for a very wide range of services to meet human needs. Services that may be funded include child care, protective and emergency services for children and adults, home-based services, information and referral, transportation, education and training, and many other services to meet the needs of children, youth, handicapped persons, and older individuals.

The Administration proposal to amend this law -- introduced by Congressman Bill Frenzel as H.R. 2720 -- makes two important changes that strengthen the program.

The key feature of the SSBG is its flexibility --instead of having management decisions made for them in Washington, State and local governments can decide which services have the highest priorities, who ought to be eligible for services, and how the services will be delivered. The Administration proposal extends that flexibility to Federally recognized Indian tribes, consistent with the President's statement of policy in January 1983, by allowing SSBG funds to be sent directly to sovereign tribal organizations. This approach recognizes the diversity among tribes and the right of each tribal government to set its own priorities and goals. The proposal also authorizes tribes to consolidate funds received under the SSBG and the Low Income Home Energy Assistance Block Grant.

Second, our proposal would add to title XX a nondiscrimination provision modeled on the nondiscrimination provisions in the health-related block grants administered by the Department of Health and Human Services. This provision expressly recognizes the application to programs or activities funded under this title of the Age Discrimination Act of 1975, section 504 of the Rehabilitation Act of 1973, title IX of the Education Amendments of 1972, and title VI of the Civil Rights Act of 1964. The provision also prohibits discrimination on grounds of sex, and specifies a procedure for securing compliance with these nondiscrimination requirements.

Aid to Families with Dependent Children-Unemployed Parent

I would also like to take this opportunity to express our objections to two proposals for new domestic spending programs which recently were adopted by the House Committee on Ways and Means as part of H.R. 3128. In addition to opposing these proposals on substantive grounds, the Administration feels strongly that it is inappropriate to initiate new spending programs in these areas at a time when the Federal deficit is approaching $200 billion.

First, the Committee's proposal would mandate that States provide benefits to two-parent families in which the principal earner is unemployed. This would disrupt a sound legislative compromise first adopted in 1961. Under the current system, States may decide whether they have sufficient resources or interest in providing AFDC to families with both parents in the home. Many States do not want to run Aid to Families With Dependent Children-Unemployed Parent (AFDC-UP) programs because they have strong philosophical objections. Also, many States feel that they do not have the funds to support an AFDC-UP program. Mandating AFDC-UP would result in additional Federal costs for AFDC and Medicaid of approximately $311 million in FY 87 alone, and would impose similar total costs on about half of the States. We estimate, for example, that Colorado would incur additional AFDC costs of approximately $6.5 million; Louisiana would incur over $8.5 million; and Oklahoma would incur over $6 million. These estimates do not include the vast Medicaid costs the States would incur. In the past, Congress has wisely balanced conflicting needs and interests by making this program available at State option, and I strongly urge you to leave this structure intact.

This proposal also would require a new definition of a quarter of work, an essential element in determining who is unemployed. This change which would seriously distort the intent of the unemployed parent program by extending benefits to individuals with very limited work histories. Currently, in order to qualify for benefits under the unemployed parent program, an individual must have six or more quarters of work within any 13-calendar-quarter period ending within one year prior to an application for assistance. The new definition would undermine this need for recent participation in the workforce by allowing education and training to substitute partially for employment in meeting the requirement for six prior quarters of work.

Teenage Pregnancy Block Grant

The second proposed new spending program, would provide additional funds to States for programs to reduce teenage pregnancies and assist teenaged parents. This provision duplicates existing efforts under a number of other programs. While we certainly share the Ways and Means Committee's concern about the problems associated with teenaged pregnancy, programs such as the Adolescent Family Life program, the Social Services Block Grant, Title X of the Public Health Service Act, the Job Training Partnership Act and other programs already provide services to assist this group of individuals. We do not believe that the additional funds provided under the block grant program will produce effective new approaches to resolving the problems of pregnant teenagers and young parents, and may indeed only serve to complicate service delivery. Moreover, the Administration steadfastly opposes creation of program which would encourage, promote or finance the performance of abortions.

For these reasons, we urge you to reject these two legislative proposals.

Aid to Families with Dependent Children—Quality Control

The quality control system is a vital and necessary part of the Aid to Families with Dependent Children (AFDC) program, and it is now seriously threatened by legislation introduced in both Houses of Congress. Both S. 1362, introduced by Senator Evans, and H.R. 3128, approved by the House Ways and Means Committee, seriously undermine the integrity of the AFDC quality control system. Furthermore, enactment of either bill would have serious budget ramifications, thus inhibiting efforts to reduce the Federal deficit.

It is the quality control system which tells us how much money spent for AFDC benefits is misspent. The measure of this misspending is the payment error rate. In FY 1973, the error rate was 16.5 percent--that is, 16.5 percent of all of the money paid in AFDC benefits was misspent. Had the FY 1981 error rate been that high, $2.1 billion would have been misspent in that year. Even with the actual error rate of 7.6 percent, almost $1 billion was misspent.

We estimate that S. 1362 would add to the Federal budget over $1 billion for the period FY 1986-1990. These costs represent additional Federal financing of erroneous AFDC payments, not increased benefits to assist those in need.

The legislation pending before Congress would raise the error tolerance level. To what degree should the Federal government finance erroneous State payments? Just three years ago, in the Tax Equity and Fiscal Responsibility

Act of 1982, Congress, while affirming a 4 percent tolerance for FY 1983, established 3 percent beginning in FY 1984 as the maximum level of erroneous payments that the Federal government should match.

As evidenced by declining error rates, States are responding to the strong message Congress sent--that States must improve program accuracy. The error rate standards have been in place for several years, and States have had ample opportunity to take the necessary corrective actions in order to achieve the target error rates. Yet S. 1362 would impose a moratorium on the collection of disallowances by the Federal government. Clearly, Congress would send both the States and the taxpayers the wrong signal by such an action. The entire amount of the disallowances for FY 1981, $69.2 million, represents only about 7 percent of the total amount of erroneous AFDC expenditures for that year and is less than half of one percent of all AFDC expenditures for FY 1981.

Now I would like to comment on some of the particular features of S. 1362, most of which are also contained in H.R. 3128.

Section 1 of the bill directs completion of a one year study to determine "tolerable" error rates for the AFDC program. In addition, it requires the Department to contract with the National Academy of Sciences to conduct a study on the same issue concurrently.

Section 2 would increase the error rate tolerance level for Federal funding from 3 percent to 4 percent retroactive to fiscal year 1983. I see no basis for increasing existing statutory tolerance levels. This provision alone would increase Federal funding for AFDC errors by about $60 million per year, including retroactive payments to States of $180 million for overpayments and payments to ineligible individuals which have been made during the past three years.

We oppose increasing the error rate tolerance level. Based on experience with States, we believe that current tolerance levels are achievable and that there is no need to provide additional Federal financing for erroneous payments. A change in the current error rate tolerance level would certainly reverse the downward trend of States' error rates.

Section 3 of the bill would make several changes to the current QC waiver process of disallowances. First, the bill would allow a State to request a waiver if the State can show that the Federal error rate determination was made incorrectly and that the State's error rate is actually lower. This section also requires the Department to act on the State's waiver request within a timetable specified in regulations, and that the State may appeal the Secretary's waiver decision to the HHS Grant Appeals Board. The section of the bill would place in the statute factors that the Department must consider in reviewing a State's waiver request, including factors now in regulation and additional factors. These additional factors include consideration of the State's past performance and the cost-effectiveness of error rate reduction.

We believe that the overall purpose of the study--to determine tolerable error rates under the AFDC program--is not only unnecessary, but unrealistic. The overriding issue in establishing error rate targets is to what degree the Federal government should participate in erroneous expenditures.

The AFDC Quality Control system has been the subject of numerous studies, including studies by Westat and Gallup, which have pronounced it both programmatically and statistically sound. Over the past twenty years, the system has undergone continual refinement and review resulting in a methodology that equitably measures erroneous AFDC payments.

Finally, a recently completed study by Touche Ross, Inc., addresses the issue of client-caused errors, and cost-effective means for reducing both client-caused errors and agency-caused errors. The study establishes beyond doubt that States can and should control their error rates, and that effective error reduction can be accomplished at a reasonable cost. Based on a survey of twenty-three States, the study also shows that many States have not fully implemented the low-cost practices identified which appear to have the greatest impact on AFDC errors. For example, regular State review of local office activity as well as supervisory review of AFDC cases are relatively inexpensive corrective action activities that were found to be effective means for controlling errors. The Touche Ross study was sent to all States to use in implementing low-cost error reduction techniques. We feel strongly that additional research cannot provide a basis for rejecting the existing quality control system.

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First, we believe it is unnecessary to allow a State to request a waiver of all or part of its disallowance if it can show that the error rate determination was made incorrectly. Under current procedures, the Federal government and the States review disputed items, in detail, before the final error rate is determined. When differences between Federal and State findings are identified, a "difference letter" is prepared for each case, and appeal procedures are provided at difference levels. Once a final resolution of whether there was an error is reached, the official error rate is determined by a formula which takes into account both State and Federal findings. Although the Regional Commissioner of Social Security is the last step in the appeals process for "difference cases", the State can also bring any disputed findings to the attention of the Departmental Grant Appeals Board when appealing a disallowance.

Second, we oppose placing waiver criteria in the statute because it would limit the current flexibility to amend such factors in response to changing technology and program requirements that could affect States' waivers. States are provided with a detailed listing of the weights and factors along with the "Notice of Intent to Disallow Federal Funds." Placing the waiver criteria in the statute would not allow us to respond in a responsible and timely fashion to changing circumstances.

Third, with regard to the additional factors which would have to be considered, we feel that they are either unnecessary or would be administratively burdensome for the States and the Federal government.

In order to determine the cost-effectiveness of error rate reduction, we believe that States would have to document on an item-by-item basis all corrective actions, including administrative decisions which were considered but rejected. Each of these items would be subject to a cost-benefit analysis. In addition, consideration of cost-effectiveness is already invariably involved in a State's selection of corrective actions, as it weighs this factor in deciding which error reduction techniques to pursue.

Section 4 of the bill would prohibit HHS from collecting any disallowances until after completion of additional studies. I strongly oppose placing a moratorium on the collection of QC disallowances. In FY 1981, States paid nearly $1 billion in AFDC benefits to individuals who were not entitled to any benefit or were not entitled to the benefit amount they received. Of this $1 billion in misspent taxpayers funds, States' disallowances totaled $73.5 million--less than 8 percent of the total erroneous expenditures. I decided, after careful personal review, to waive $4 million. Thus, in perspective, States are being asked to reimburse the Federal government for a relatively small portion of the funds misspent that year.

Concerns expressed about the effects on States, and the AFDC program, regarding the collection of the disallowances are overstated--many of the States subject to disallowances have State budget surpluses. According to a published 1985 survey conducted by the National Association of State Budget

Officers and the National Governors' Association, many States showed budget surpluses for FY 1984 and for FY 1985 (estimated), including the majority of States subject to disallowances for FY 1981.

FY 1981 is the first year for which disallowances will be collected. The implementation of these QC error standards, including collection of disallowances, should not be a surprise to anyone since Congress mandated the standards in 1979. To place a moratorium on the collection of disallowances now will send a message to States that the QC system is to be disregarded and that there is no need to reduce erroneous expenditures in the program. Yet, as we reduce erroneous expenditures we show the taxpayers that the program is responsible and effectively targeting assistance to those in need. By improving the image of the AFDC program, we gain public support for this vital assistance program.

Section 5 of the bill would establish incentive payments when a State's error rate is below 4 percent, starting in FY 1986. These incentive payments would not be in effect until after the moratorium on disallowances is lifted, and at that time incentive payments for prior years would be made in a lump sum to States.

We believe it is unnecessary and unwise to institute incentive payments beyond the existing rewards which accrue to States that meet their target error rates. When States successfully reduce errors below the statutory limit, States not only share in the savings but also reap the non-financial benefits of obtaining public respect for a job well done.

Section 6 of the bill would require that a State's error rate be determined using the lower bound of the confidence interval rather than the midpoint. In addition, errors which are said to be "technical" in nature, such as omissions from the State files of Social Security numbers, assignment of child support rights, declarations of cooperation in obtaining child support and WIN or other work program registrations shall be disregarded. These amendments would apply to FY 1981 and thereafter.

We believe the appropriate solution to a State's concern about the reliability of QC results is for the State to increase its sample size--an option which is currently available to all States--with federal matching payments available for added sampling costs.

Moreover, there are other serious problems inherent in the use of the lower bound. For example, use of the lower limit would give an advantage to a State with a small sample and larger confidence range and disadvantage States with a large sample and smaller confidence range, although the mid-point estimates could be the same in both cases. Use of the lower bound would also give an advantage to States with high error rates--when two States have the same sample size, the confidence range is larger for the State with the higher error rate. Also, the bounds of the confidence interval are affected by the extent to which Federal and State findings differ. In computing the error rate, the AFDC quality control system uses a regression methodology that takes into account difference in Federal and State findings. As the differences between those sets of findings increase, the confidence interval expands, and the State's error rate, if measured at the lower bound, would be reduced. Thus, there would be no incentive for States to conduct accurate QC reviews and minimize their differences with the Federal findings. Such difficulties exist regardless of the sample size.

We also oppose not counting "technical" errors. These so-called "technical" errors involve basic statutory conditions of eligibility. In fact, these requirements are central to the administration of the AFDC program and their proper documentation is a necessary element of any meaningful QC review. These conditions are subject to quality control review to determine whether the case was legally entitled to receive assistance and, hence, whether Federal matching is allowable. Further, quality control data show that compliance with these requirements is within the control of the State agencies and, in fact, compliance is almost totally achievable through solid management attention.

We also strongly disagree with the assumption that these so-called "technical errors" have no fiscal impact. These requirements were placed in the statute because they do have programmatic, administrative, and fiscal impacts. Clearly, compliance with and documentation of these requirements can have a substantial effect on eligibility and payment amount. For example: if the State fails to document a Social Security number (SSN), a bank or wage match could not uncover excess resources or earnings. Furthermore, the income verification requirements that Congress recently enacted in the Deficit

Reduction Act of 1984 require States to use SSNs to match applicant and recipient AFDC information with Employment Security, Unemployment Insurance, SSA, BENDEX, IRS and other Federal and State data sources to ensure that applicants and recipients receive only those amounts to which they are entitled under the law. If the SSN documentation requirement were deleted from the calculation of States' error rates, we believe States would not be as diligent in securing SSNs and, as a result, the income verification process would be considerably less effective.

I urge you not to divert scarce dollars to finance greater waste payments. In a time of staggering deficits and many pressing demands on the Federal government, subsidy of bad welfare management is not supported by the public and should not be supported by the Congress.

Error rates are coming down. The system is working. To undercut that system now would undo twenty years of Congressional commitment to proper stewardship of public resources. To destroy the structure which Congress has taken so long to develop would be shortsighted and fiscally irresponsible.

AFDC ADMINISTRATION PROPOSALS

This year the Administration is proposing four amendments to the Aid to Families with Dependent Children program. These proposals build on earlier changes made during the Reagan Administration by promoting self-reliance, improving administration, and targeting of AFDC benefits.

The most significant of these amendments calls for the creation of a work opportunities program. It embodies a workable, fair and responsive approach for assisting AFDC applicants and recipients in their efforts to become self-sufficient.

We believe the work opportunities program is necessary if AFDC is to succeed in one of its primary missions -- to give parents the chance to control their own lives by engaging in meaningful employment. The work ethic that shaped our nation and drives our lives is alive in AFDC recipients. They feel the need to work and contribute to society as strongly as any American. The problem is they lack essential tools -- not just the skills and work experience required for particular jobs -- but also self-confidence and self-esteem. Our work opportunities proposal would provide AFDC recipients with the opportunity to develop these essential tools.

The work opportunities proposal replaces the Work Incentive Program -- which has failed to involve large numbers of recipients in work activities, and has not dealt effectively with recipients without job skills. Under our proposal, for the first time, all States would be required to involve actively all non-exempt able-bodied AFDC applicants and recipients in work activities. The work opportunities proposal places primary responsibility with the welfare agency and allows States to offer a wide range of work activities including:

- the Community Work Experience Program, in which recipients are assigned to work in public and non-profit agencies while continuing to receive their welfare grant;
- grant diversion, in which the welfare benefit is used to subsidize a pay check received by the recipient for performance on a job;
- job search, in which applicants and recipients are required to look for work while they receive support services;
- Job Training Partnership Act, or JTPA, training; and,
- State-designed alternative work-directed activities or innovative projects approved under HHS demonstration authority.

States would have the flexibility to design programs which respond to their local needs, and would have a three-year period to achieve required participation rates. No recipient would suffer due to participation in these programs; we would continue to exempt from this requirement individuals such as the aged, disabled, and those who face special responsibilities for providing care at home.

This proposal builds upon a number of successful State work programs made possible by changes sought by the Administration during the past four years. Recent data from the State provides strong and consistent evidence that work programs do work. I would like to point out just a few of these findings:

- In a San Diego work program that combines job search and the community work experience program (CWEP), over 90 percent of the 5,000 welfare recipients expected to participate found jobs, left the rolls, or completed the program within 9 months of entering the program.
- 52 percent of the mothers in the San Diego project participating in job search and CWEP found jobs -- an employment rate 25 percent higher than the rate for non-participants.
- Polls in San Diego and North Carolina showed that nearly 90 percent of the public supported work activity for welfare recipients. Even more striking, surveys have consistently indicated that program participants overwhelmingly agree that work requirements are fair.

The work opportunities proposal would result in a net Federal AFDC savings of $52 million and a Medicaid savings of $157 million in FY 1986, savings which would be achieved without any decrease in benefit levels.

The other three proposed AFDC amendments would:

1) when calculating benefits for the AFDC assistance unit, exclude the needs of employable parents or caretakers when the youngest child reaches age 16. This proposal phases out assistance gradually, when the caretaker's freedom from child care responsibilities permits pursuit of employment opportunities. Currently, assistance for the entire family ends abruptly when the youngest child turns age 18 or 19, and there is no period of transition from dependence on welfare to self-support.
2) with certain exceptions, require minor caretaker relatives to live with their parents in order to receive AFDC assistance. The intent of this provision, which complements legislation enacted by

Congress last year, is to ensure that the incentives and requirements of the AFDC program do not cause teenage mothers to leave their families.

3) provide States with fixed amounts for AFDC administrative costs based on their 1984 administrative expenditures, adjusted by the GNP deflator. Work program related administrative expenditures would be excluded, and a separate amount would be allocated to States for these costs. This proposal will encourage States to administer their programs more efficiently and will reduce reporting requirements associated with cost allocation.

Together, these three proposals would result in additional Federal AFDC savings of $159 million and Federal Medicaid savings of $103 million in 1986. Both the caretaker relative and minor mother provisions received favorable consideration by the Senate Finance Committee last year. All of these AFDC amendments have been incorporated in S. 1081, which has been introduced by Senator Roth.

This bill encourages meaningful work opportunities for people living in poverty, promotes family life, and seeks sensible administrative improvements. It is worthy of your support.

CONCLUSION

Mr. Chairman and Members of the Committee, as you follow the reconciliation process to a conclusion, I urge you to be ever mindful of the problem which the process is meant to address: the Federal Government's deficit. At the same time, we hope you will follow your Committee's traditional, well-respected practice of recommending balanced and fair proposals.

And let us not merely question how much we are spending, but at the same time question how we are spending. Let us work together and keep an open dialogue on ways to effect meaningful reforms in Medicare, Medicaid, AFDC, and the other social service programs within this Committee's jurisdiction. Together, we can make this possible.

The **Chairman**. Senator Durenberger.

Senator **Durenberger**. Madam Secretary, let me agree with you in terms of the progress that is being made in health system reform. And the reason that it is being made is that there is a whole lot of cooperation going on out there.

Let me make the observation that in the last 4 years I think we have saved in a budgetary sense, something in the area of $29 to $30 billion, without, I think, visiting the wrath of ill health on a lot of Americans.

And this year we propose in the Senate side to save another $16.3 over a period of time. We are going to end up at about $11 billion.

I have to say on behalf of a number of us here that that didn't have a lot to do with system reform, other than that system reform enabled us to make some of those latter savings. I'm talking about the $16.3 and the $11 billion.

Do you have some kind of data on hospital reimbursement comparing base plus a cost of living adjustment versus what they got this year plus 1 percent, versus what they got this year as a freeze or zero? I mean what leads you to the opinion that all of the hospitals in the country are as well off at a freeze versus a 1 percent increase, versus a cost of living?

Is there data somewhere that demonstrates that if we really care about hospital reform and all the things that are happening out there that hospitals and people are better off at a freeze than they are at a freeze plus 1 percent or a freeze plus a cost of living?

Secretary **Heckler**. While we cannot speak for each hospital, because there are potential variations among hospitals, we feel very strongly that overall care provided by the hospitals is very good. We also feel strongly that it's very important to continue with the transition into prospective payment. While we do not have 1984 profit data for hospitals under the Medicare prospective payment system, one industry publication, Modern Health Care, on January 18, 1985 indicated that in the first year under prospective payment most hospitals increased their profit margins. This was especially true for major teaching hospitals.

Hospitals, on May 1, 1985, also reported that, between 1983 and 1984, total revenue margins for the hospital industry rose by 1.1 percent.

Senator **Durenberger**. The data is in Modern Health Care?

Secretary **Heckler**. We do not have profit margin data.

Senator **Durenberger**. Let me ask you a second question.

One of the things that a prospectively priced system does is that it shows the inefficiencies in your basic system. So when we prospectively priced a lot of inhospital products, we found out that those products could be delivered more cheaply on an outpatient basis. So we had a variety of products that the hospitals were moving from part A to part B.

They were actually collecting more money by going to part B than they had been under the DRG system in part A.

So some of us on the House and Senate side came up with the notion that we ought to recognize that reality that these products can be produced cheaper outside of the hospitals so we came up with this recommendation on outpatient, so-called outpatient, surgery.

Can you tell me what is wrong with the notion that the Medicare trust fund and people might not save a lot of money by taking advantage of what prospective payment on part A has shown us to be inefficiencies on inpatient treatment and efficiencies of outpatient treatment?

Secretary **Heckler**. We support the basic design of your outpatient surgery, proposal, Senator, which has a great deal of merit.

However, we feel that care must be taken to estimate the potential savings. And until we have the kind of data and information that we feel is necessary, we don't feel that that kind of a change should be supported.

Senator **Durenberger**. So that just leads me to the bottom line that I really didn't want to get into. And it's a good thing the yellow light is on.

And that is that my problem is not this year. My problem is the next 3 years that I'm stuck with this administration. And we have got a lot of effort invested—and this is not critical of you, Madam Secretary.

Secretary **Heckler**. I hope not. [Laughter.]

The **Chairman**. Just edit the transcript. [Laughter.]

Secretary **Heckler**. I don't know that I'm relieved, Senator. [Laughter.]

Senator **Durenberger**. The point being is that if there is going to be solidarity in reform, it can't be selective solidarity. We can't say to your experts in 1983 produce some information on capital reform and have you not produce it 2 years later. We can't say to you produce some recommendations on graduate medical education, and 2 years later you haven't produced anything. Or say to you produce something on outpatient surgery, and you say, well, we don't have the data.

But when it comes to freezing GME in place, and freezing the indirect in place, and freezing the hospitals in place and doing all the things that Dave Stockman told you to do—I mean you can come out with the regulations pretty quick.

And my concern is, is that going to happen again next year? Is it going to happen in 1987 and 1988? And if is, I'm not so sure I want to be a budgeteer this year.

Do you have a view for the future of——

Secretary **Heckler**. Yes. I think that we are closer together in terms of our concerns than it would appear. Looking at the issues from the perspective of making regulatory decisions, it is absolutely impossible—and also I think obviously unwise—to proceed on a regulatory course in an area in which you do not have solid data.

And what we are gaining is the ability to gather information and data at a much faster pace. As you know, the whole prospective payment system instituted a new course, a new direction, in terms of reimbursement policy. We had very little data upon which to base some of the decisions that were made.

There were winners and losers among those who were the providers. As we proceed along the course of implementing the system as we gather the data, we no longer have to proceed on the guesstimate.

What is the best guesstimate? I think it's the height of foolishness to make very substantial health care decisions without having the information as backup to ensure that across the country—in rural areas and in urban areas—the impact will be valid.

We are very, very concerned about program reform and about continuing to improve the system. We are looking at refinements. Our research is getting better all the time. But we feel that before we proceed with more extensive changes research should have been conducted.

Data are becoming more available, and the exchange of information continues. While it may not appear to be as firm as I could state it—I want to assure you that we are making progress.

On disproportionate share, for example, we are as concerned as you and consider it essential to the program. Yet, unless we can find a valid way to assess what hospitals, if any, are bearing the disproportionate share of low-income Medicare and Medicaid patients, we feel it's ultimately unwise and imprudent to enact a law or issue a regulation that will resolve the question based on guesstimates.

Senator DURENBERGER. I think that's very responsive. The administration will continue to use lack of data or data to be selective use of regulations to achieve its part of solidarity.

The CHAIRMAN. What did you say? [Laughter.]

Senator DURENBERGER. We are going to have more freezing.

Senator MITCHELL. Mr. Chairman, that wasn't as clear as his earlier statement. [Laughter.]

The CHAIRMAN. Senator Bentsen.

Senator BENTSEN. Mr. Chairman, I have heard the Senator from Minnesota make many profound and eloquent statements, but I think his earlier statement was one with which I have a great deal of sympathy. And I must say there will be those that will try to relieve him of that burden of this administration. [Laughter.]

Senator BENTSEN. But, Madam Secretary, I think there is a lot to be said in commendation insofar as turning around the incredible escalation in medical costs. But I have some concern from what I have seen happen over on the House side insofar as stopping the transition to national rates under DRG. And I understand from what you have stated, your opposition to the stopping of that transitional period.

Would you recapitulate for the members of this committee some of the savings that have been attributable to the DRG incentive which have been realized over the last couple of years?

Secretary HECKLER. Actually, Senator, we have seen and witnessed a true evolution in health care in the sense that the hospitals under the new prospective payment system have for the first time been mandated by law to apply management efficiencies to their operation of hospitals.

And as those efficiencies were made, as the prospective payment system was phased in on a national basis, we have seen very dramatic changes in hospital management procedures without a reduction in any way of the quality of care.

This was, in effect, squeezing the fat out of the budget in terms of reimbursement. But some of the specifics——

Senator BENTSEN. Can you give me a feeling of numbers?

Secretary **Heckler**. For example, the reduction in the length of stay.

Senator **Bentsen**. 7.7 days.

Secretary **Heckler**. Right.

Senator **Bentsen**. Now how about total money? Can you talk about dollars?

Secretary **Heckler**. The first regulation was issued under the requirement of budget neutrality. So, for the first 2 years under the Tax Equity and Fiscal Responsibility Act [TEFRA] we were required to keep the prospective payment system budget-neutral so we would not have spent more than we would have spent under the prior system.

Today's efficiency means lower payments will occur in the future. Although we don't have the exact figure, we know outlays have been reduced. Between 1975 and 1980, Medicare outlays were growing at about 18 percent. Last year, fiscal year 1984, this rate was 8 percent.

However, the changes that have occurred, are reflected in changes of behavior in the medical community aside from prospective payment. There are behavior changes in hospitals affecting non-Medicare patients, creation of competition in the marketplace such as the creation of Health Maintenance Organizations [HMO's], which will provide the same services at 95 percent of the cost. We have 60 HMO's already federally certified within only 5 months; they treat 360,000 patients. We do not see the immediate cost savings, but they are definitely in the pipeline; more will be reflected next year.

There are literally billions of dollars of savings that have been influenced by prospective payment per se.

Senator **Bentsen**. Madam Secretary, my time is so limited. I appreciate an answer in actual dollars, in addition to what you have stated.

But I would also like to ask you on—on the House side they are talking about a special Medicare subsidy for hospitals that have a disproportionate large portion of low-income persons. And I understand your questions concerning it, but I think there is legitimacy to that concern. And, hopefully, we can find numbers that will give us a better feel for it.

But it would seem to me that if we go in that direction that we also ought to include rural hospitals. And I would like to have your statement concerning that.

Secretary **Heckler**. We do not favor the direction taken by the House.

Senator **Bentsen**. I understood that. But if you face that, what will you do about rural hospitals? My understanding is that they have not included rural hospitals on the House side.

Secretary **Heckler**. We believe that any proposal definitely should include rural hospitals. But we don't feel that the yardstick, the proxy for low-income chosen—that is, the Medicaid patients that hospitals care for—is the right measure for disproportionate share.

For example, Massachusetts has a very rich Medicare and Medicaid package of health benefits. A State such as Texas might have one that is not as generous. And yet, under a national system, hospitals in Texas could be penalized. The Massachusetts hospital could receive more money for serving a disproportionate share, while the disproportionate share of care given by the Texas hospital might not be reflected and this would not be compensated.

We think that's the greatest flaw in the approach taken by the House Ways and Means Committee. We do not suggest an alternative at this time, but we are very aggressively searching for one. And we feel very strongly that the alternative should be a national answer; it should not be one that deals with urban hospitals exclusively.

Senator BENTSEN. Thank you, Madam.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

Madam Secretary, one of the issues that was brought to our attention as a nation quite forcefully about a year and a half ago was the *Katy Beckett* case, a young girl who had to be on a respirator in a hospital, but who could have been just as easily, much more humanely, and at a less cost to all concerned, been treated in the home.

As you are aware, I have introduced legislation, S. 1249, to permit home respiratory care. As you know, the President himself had to intervene apparently with your Department to get an appropriate decision made.

Would the administration support our legislation?

Secretary HECKLER. We have not taken a position on your legislation at this point, Senator.

Senator HEINZ. Would the administration please look at S. 1249?

Secretary HECKLER. Yes.

Senator HEINZ. I think you will find that it is fiscally responsible. It will be revenue neutral. And it will certainly be humane. I think anything we can do to avoid the cost and heartbreak of the current situation is to be seriously considered.

Second, another issue that has concerned me for some time is the amount of unnecessary surgery taking place in the United States. We all know that unnecessary surgery represents costs to everybody; it represents trauma; and it represents risk to the people who must undergo unnecessary surgery. It also costs the Federal Government and the Medicare Program a considerable amount of money. Estimates range up into the billions of dollars.

A recent issue of the Washington Health Cost Letter states that Mr. Haddow, the acting HCFA Administrator, personally favors a mandatory second-opinion program. The letter states—I hope it's correct—that you, Madam Secretary, are leaning toward that position as well for a mandatory second opinion on certain categories of surgery.

CBO has estimated that such a program would save about $260 million for Medicare and Medicaid over the next 3 years. The inspector general at HHS, Mr. Kusserow, long favored a mandatory second-opinion program, as has your Office of Research and Development and the Bureau of Quality Control.

I understand that you may be reconsidering your position in light of the very recent update of the ABT Associate study, which was conducted by the Department, which reconfirmed the effectiveness of a mandatory second-opinion program.

Can I anticipate supportive and welcome good news on that subject?

Secretary HECKLER. We definitely are reviewing the subject, Senator. Mr. Kusserow has argued strongly in favor of the position that you take, and the new, interim, acting Administrator has spoken out as you have relayed.

Your work has been very impressive in this area, and it's something that will be the subject of future action on the part of the Department.

Senator HEINZ. Well, I hope you will. We are going into markup on Tuesday, and a quarter of a billion dollars is, frankly, nothing to sneeze at.

We have a very strong letter in support of a mandatory second-opinion program—indeed, in support of the legislation specifically that I introduced, the Second Opinion Act of 1985—from the American Association of Retired Persons. It's signed by Cy Brickfield. To the extent that there are people who have concerns about any such program, it tends to be that somehow little old ladies in tennis shoes aren't going to want to be told that they have to have a second opinion.

Now there are waiver provisions that are flexible, and are going to take into account inconvenience and hardship. I hope in the light of the fine tuning of that legislation, which has been pretty carefully crafted, that you will be able to give us your support.

One other issue I would like to ask about is the AFDC automation question I brought up with Senator Evans when he was here. Both Medicaid and AFDC's in 1980 started receiving incentive payments; 75 percent for Medicaid, 90 percent for AFDC; 49 States have put in automation for Medicaid; 3 have put it in and been certified for AFDC.

It seems to me that we ought to be a lot tougher on States that are not meeting their deadlines. Do you have any objection to our legislating, your being able to reclaim the incentive money that we paid if we haven't gotten anything for it when we should have?

Secretary HECKLER. I would have no objection. In fact, I would appreciate it.

Senator HEINZ. You are welcome.

Secretary HECKLER. Thank you.

Senator HEINZ. We will try and accommodate you.

Secretary HECKLER. All right.

The CHAIRMAN. Senator Mitchell.

Senator MITCHELL. Thank you, Mr. Chairman.

Welcome, Mrs. Heckler.

Secretary HECKLER. Thank you.

Senator MITCHELL. It's a pleasure to have you before the committee.

Under the assumptions in the budget resolution this year, coverage under the Retirement Disability Insurance Program, and Social Security system, would be mandatory for new employees of State and local governments. Coverage under the health insurance or the Medicare Program would be mandatory for current and new employees of State and local governments.

In 1981, President Reagan publicly stated his opposition to mandatory Social Security coverage for employees of State, county, and municipal entities.

I have two questions for you. First, what is the administration's position now with regard to the budget conference assumptions regarding mandatory coverage under Social Security for such employees?

Second, if the administration supports those assumptions, what factors led the President to reverse his position on these issues?

Secretary **Heckler**. The administration has not changed its position on the universal coverage issue. The issue has been debated; is still being debated. But it is not one for which there has been a change of position.

Senator **Mitchell**. So do I understand what you are saying is that the President and the administration oppose mandatory coverage as contained in the budget conference assumptions?

Secretary **Heckler**. At this time, yes.

Senator **Mitchell**. When you say "at this time," it certainly creates the impression that you are considering reversing the position. Is that a fair inference?

Secretary **Heckler**. That is a fair inference. It's a possible area of change, but I would not encourage you to believe that a change is imminent.

It is being discussed, however.

Senator **Mitchell**. May I ask that you notify the members of this committee if at any time that position changes. Until then, I understand we are to operate under the understanding that the administration's position continues in opposition to those assumptions.

Secretary **Heckler**. Yes; I would be very happy to, Senator.

Senator **Mitchell**. I would like to ask you a question in another area. And that involves regulations covering intermediate care facilities for the mentally retarded.

As you may be aware, in the 1985 edition of the Life Safety Code for Self-Preservation in such facilities, certain standards were promulgated. HCFA has been for some time in the process of developing new regulations which I understand incorporate the provisions of the 1985 edition of the Life Safety Code.

However, that has taken a long time. And although HCFA has completed the final recommendations and they are now under review, apparently in your office, in the meantime, interim regulations have been issued which are much more stringent than the 1985 Life Safety Code.

This has produced a true dilemma in many cases, and I will cite specifically a case I learned of yesterday when I met with State officials. There are approximately 400 elderly persons, mentally retarded, in such facilities in Maine. It is estimated that most of them could not meet the currently applicable interim standards, but could meet permanent standards that are now under review and have not been promulgated.

Under the interim standards, if they can't meet them, they must leave those facilities within 5 days. And they have been told by HCFA that they must go one or two places—either back to their home or to a State facility.

In many cases, these people have no families and therefore no homes. In many other cases, they do have families, which are wholly incapable of caring for them.

So for a certain number of them, they can't go to a home.

On the other hand, the State facility has been operating for some time under a federally court-imposed consent decree limiting the numbers of persons who can be sent there. So if HCFA's directive in those cases is obeyed and they are returned to the State facility, they will be violating a Federal court order.

All of this arises because the permanent regulations have been delayed and have not been promulgated. My question to you is: Are you aware of this problem? Are you going to issue those regulations? When are you going to issue those regulations? And if you are not going to do so in the immediate future, what action will you take to resolve the dilemma that exists in Maine and perhaps in other States?

Secretary HECKLER. Senator, as you know, the Administrator of HCFA just left at the end of August. And one of the last actions taken before she left was to send to departmental clearance the final regulations.

The executive clearance process will involve consideration by all of the assistant secretaries, which, unfortunately, is not very short because it involves the resolution of details and controversy within the Department.

I can see that the dilemma that you have posed is a very acute one. I can assure you that we will take a special interest in the problems that you have cited in Maine and other related problems of the same nature because, obviously, those people who are hung in the balance need to have a determination. As you pointed out, if there are no other shelter opportunities for them, this is a critical and time-sensitive problem.

We are anxious to expedite the final rewriting of the regulations. But in the interim, the kind of acute situation that you have described will get our immediate attention.

Senator MITCHELL. Thank you.

The CHAIRMAN. Senator Long.

Senator LONG. No questions, Mr. Chairman.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Might I suggest, as a followup to George's last question, then, that you might consider suspending the look-behind audits that are taking place out there now? Because they are just confusing the heck out of Geroge's administrators, mine, and a lot of others.

So, if it is a matter of doing that regulation right, and that is what is holding it up, and resolving conflicts, then why don't you just tell us now, if you could, that you will call the regional administrators out there and just call off this inspection process or change it in some fashion until the regulations come out? Could you do that?

Secretary HECKLER. I don't think that would be advisable, Senator. There are many conditions that are life-threatening in institutions in which some of our most vulnerable citizens reside. And our "look-behind" is a limited effort to try to examine conditions. We do not have a vast squad of personnel who are available to do the kind of inspection that would be useful. As we proceed, the kind of information we gain will be measured against the final standards. But it is very important to us to continue to do the look-behind inspections, because they can reveal truly shocking and life-threatening circumstances in many facilities.

Senator **Durenberger**. Well, wait a minute. I don't think my State is about to want to be characterized as having a shocking situation in its intermediate care facilities. When those inspections are conducted in an environment in which the Federal policy was that we would have the States, in effect, oversee this process, the Feds will make sure that the States are properly overseeing it.

Now these inspectors are going through this, the Weickers inspectors, or whatever we want to call them. They are going through the facilities, ringing the fire alarm bells. And a lot of these people, if they haven't had some training, you know, are not running out the doors. So they are talking about shutting down these facilities.

Well, for years and years and years that is the way the State, with Federal approval, has been running that particular system.

But what is bothering me is that your inspectors, the 49 of them or whatever that are out there around the country, aren't taking the State people with them. So if you are going to keep doing this sort of thing, why not take the State people along with you so that there can be some discussion on the scene about the conflicts between what Minnesota thought it was doing that it was correct in doing and what now you, somehow or other, deem to be a different approach.

I am just trying to approach this sort of practically, because he is right—you haven't promulgated a new set of regulations, even though Carolyne has sent them up to you.

Secretary **Heckler**. Carolyne has sent them to the Department.

Senator **Durenberger**. So, they are still sitting there.

Secretary **Heckler**. Senator, if I might say, I will look into the advisability of having the State inspectors accompany our team. At first blush, I would have no objection to that. It is something that I will bring back to the Department.

But let me just say this: we have found really deplorable conditions, not necessarily in your State. For example, in some States in some of the residences the older, retarded people were not trained to leave the building in the event of a fire alarm. If they are not trained to leave when an alarm rings, then they are not being protected. That is a very basic requirement. I can't imagine that any rewrite of regulation would change it.

In other States, and even in my own State of Massachusetts, we have seen truly gross conditions, in which people are warehoused. And in New York State, in two facilities, we were paying $150 a day for the care of residents who—when we inspected the facilities—we found to be treated almost less worthy than animals.

Frankly, to allow that to continue is just not, I think, living up to the requirements of the law—either the spirit, or the language of the law.

The requirements of working with the States and alerting them to our basic standards is something that, of course, will be done. But when you come down to something as balck and white as simply warehousing people, giving them no training, putting them on tranquilizers all day, and then having the Federal Government pay $150 a day for that care—in my view tolerating that by not fully inspecting the conditions is not a responsible position for the Department to take.

Senator **Durenberger**. Well, I hope that George is getting the same message I am getting, and that is that this administration is about to come into our States and talk about warehousing of retarded persons and deplorable conditions, simply because we thought it would be a good idea to do a more realistic Federal audit of what States are doing. And I am not here to defend anybody's bad practices; I am only here to say those practices are as bad as we at the Federal level have permitted them to be, in fact they exist. And I am not sure they do.

I have one other question, on your calculation for home health cost limit. You want us to go from in effect an aggregate calculation to a per-discipline calculation. It only saves $14 million, it puts 3,500 home health agencies over the limit. Why are you recommending we make the switch?

Secretary **Heckler**. Well, the growth in home health agencies has been enormously large. We expect, even with these new limits, that expenditures will increase by 12 percent next year.

I feel very strongly about and am very supportive of the home health agency approach; we think it is very, very important. However, we feel that we have had liberal reimbursement rules that have led to a tremendous growth in providers.

In 1980, there were 2,924 agencies, now 5,345. A number of large companies are not getting into the business of home health care. We would like to see the limit on per-visit costs to be lower. We would like to translate the Medicare reimbursement incentives into the home health care system, because this segment of Medicare is not now based upon efficiency and good management. Home health is a terribly important segment of Medicare, but it should have the same kinds of requirements for efficiency that we have for hospitals.

Look at skilled nursing care providers. For a skilled nursing facility, we pay $60 a day which covers the cost of a room, meals, laundry, housekeeping, and 24-hour-a-day nursing care. For physicians, Medicare payment averages $30 for a specialist; $25 for a general practitioner for a house call. Under our current system of payment for skilled nursing care, the urban limit is $53.41, the rural limit $58.39 Under medical social services for home health care, we are paying $80.64 for the urban limit, and $81.55 for the rural limit, and so forth.

These are figures that have not widely considered, and the time has come for the consideration of costs on a per-discipline basis. This was the congressional intent in the Omnibus Budget Reconciliation Act. The idea is to increase efficiency, and each limt would be set at 120 percent of the mean—120 percent. This is very close to what we set for skilled nursing facilities, and we think this is an area in which there hasn't been any attempt at good management. It's about time, because it is fast-growing and very important.

Senator **Durenberger**. Thank you.

The **Chairman**. Senator Mitchell.

Senator **Mitchell**. Madam Secretary, let me say that I commend you for the concern you have indicated here for the health and welfare of persons in such facilities, particularly elderly mentally retarded persons. And I assure you that neither I nor Senator Durenberger or anyone else feels any different.

The problem is, of course, that we have a specific situation, in which, in the name of a good cause, more damage may occur to individuals, programs and facilities. Now, there are, it seems to me, two very practical solutions.

The first and most obvious is to issue the new regulations. They are overdue. That ought to occur. If that can occur promptly, then the problem will be resolved. I emphasize that the problem arises only because of the delay by the Department in issuing these regulations.

Now, if it is going to take some time to do that, some further time, then it seems to me there is an interim practical solution. In the final regulations do incorporate the 1985 Life Safety Code provisions, then in the conduct of the audits that are occurring that standard should be applied, so that States are not put in the impossible position of having to move people when they have no legal or appropriate place to put them to satisfy an interim regulation which will no longer be required, the standards for which will no longer exist, once the permanent regulation is issued. That seems to me to be a limited, commonsense, practical solution to a difficult problem that does not involve the exposure of these persons to hazard, which none of us, of course, want to do.

Secretary **Heckler**. Right.

Senator **Mitchell**. And I hope you will take that under consideration in the spirit which you have expressed, of concern, here today, for the persons, a concern which we all share.

Secretary **Heckler**. Well, Senator, I would like to say that I feel that the issue of the Life Safety Code is one upon which we would all agree. What occurs to me—since the final regulation includes many other controversial issues—that what I should consider doing is to issue a separate regulation incorporating just the Life Safety Code and creating that as a universal standard. This would allow the other more contentious issues of the broadbased comprehensive regulation to be reviewed in the regular order of business at the Department and argued by the various assistant secretaries before it does come to me for final approval. So, that is something I would definitely take into consideration as a result of this colloquoy.

[Note: the regulation was subsequently published in the Federal Register on November 5.]

Senator **Mitchell**. I think that makes a great deal of sense, Madam Secretary, a very practical, at least partial solution, and I encourage you to take that step and others that can deal with this in a reasonable way.

Secretary **Heckler**. Fine.

Thank you.

Senator **Mitchell**. Thank you.

The **Chairman**. Senator Heinz.

Senator **Heinz**. Mr. Chairman, thank you.

Madam Secretary, several years ago, after a lot of consideration by the members of this committee and on the floor, we decided to create the Hospice Program. I was the author of the Senate amendment to do that. As you may well be aware, unless we act otherwise, the Hospice Program is scheduled to sunset.

Does the administration favor sunsetting the Hospice Program, in other words having it end?

Secretary **Heckler**. I believe that the Hospice Program is a very valuable one and certainly feel that the experience we have had has been constructive. It has served a very necessary function.

Our position is that we are supporting an extension for 2 years and will review it at that point.

Senator **Heinz**. Is there any reason to keep it on such a short leash, particularly if you are saying it is doing a good job?

Secretary **Heckler**. Of course, I, too, was one of the congressional sponsors, if you recall.

But that is part of my "prior incarnation." The fact is, in this role, we are looking at refinements of the program in the future. It is a brandnew program, obviously, and one that does require some review on a continuing basis. So, we feel the prudent position is to stand behind it for the next 2 or 3 years.

Senator **Heinz**. Well, my view is that we should repeal the sunset date and realize that in fact it is a permanent program, and treat it like all the other Medicare authorities, which is that we have almost biannual or annual Medicare bills, and if we need to make adjustments in it we can and will.

I would like to ask you a question about the reimbursement rates. Is it your understanding that the reimbursement rates of the Hospice Program are in fact as much as $20 a day less than cost?

Secretary **Heckler**. That is not my understanding.

Senator **Heinz**. I would like to have whatever information you have on that.

One last question is on the administration views on separating Social Security from the unified budget. The President has endorsed that. I assume that you would agree that this is a good thing to do.

Secretary **Heckler**. The fact is that the President has charged us with exploring the ramifications of moving the Social Security Old-Age Survivors and Disability Insurance programs off budget. There are issues that will have to be analyzed with respect to that position. We are reviewing and examining program interrelationships involved in moving Social Security off budget; its possible effect on Medicare is one of our concerns.

Of course, under current law, Social Security, OASI, DI, and HI trust funds will be off budget by fiscal year 1993. At the moment, we are trying to examine the ramifications of doing that at an earlier date for the other trust fund, the SMI trust fund, and for Medicare interests and issues generally. These issues have not been resolved.

Senator **Heinz**. The President favors doing it at the earliest possible moment. He indicated that he wanted to do it effective October 1, 1985. Isn't that correct?

Secretary **Heckler**. I don't believe the President ever made the statement with that date. He is in favor of moving the OASI and DI trust funds off budget, and that is a position that we, of course, do support.

The issue of the time for achieving this is being analyzed.

Senator HEINZ. Finally, Madam Secretary, I know you haven't had a chance to look at this, but yesterday I introduced legislation, S. 1623, a three-part bill that is designed to improve the quality of PRO oversight of the Medicare system. I would urge you to look at it. I believe it will improve the quality job that the PRO's do, and I would hope we could have your Department's opinion on that legislation prior to our markup next week.

Secretary HECKLER. We will do everything we can to accommodate you.

Senator HEINZ. Thank you very much, Madam Secretary.

Secretary HECKLER. You are welcome.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman.

Madam Secretary, I would like to ask about the area wage index, the new area wage index that is going to be included in our package. I hope you have had the chance to look at that.

I would like to know, from that standpoint, if you are satisfied that that area wage index will be sufficient to provide equity for rural hospitals. You know, we have had a lot of dialog on the problem of rural hospitals. That is a very real problem in my State.

On the other hand let me say, even as I talked to the rural hospitals that are maybe really under constraints, they still feel the necessity of the right decisions in moving where we have with the reimbursements. But we are trying to further refine it.

Secretary HECKLER. Senator, as you know, we have had a great deal of difficulty refining the urban/rural index. Incidentally the Congress required us to create an urban/rural split in the reimbursement policy and actually to create such an index. We used Bureau of Labor Statistics data to develop the hospital wage index. I must underscore the need for very solid data before proceeding on such changes. Often the data are not at your immediate disposal.

The Congress then questioned the use of the Bureau of Labor Statistics data, because it did not accurately reflect the employment practices of small, rural hospitals. Upon the request of many Senators and Members of the House, we proceeded to develop a refined index which necessitated surveying every hospital in the country. And the final data which came to me indicated that still there were going to be winners and losers. Interestingly, none of those in either the winner or loser categories would be universally rural hospitals or urban hospitals; they were a mix. In fact, in those areas in which there was the greatest discrepancy in hospital reimbursement, I charged our Office of the Inspector General to go out and conduct a second audit to be absolutely sure that our figures were accurate.

They have done this. I am absolutely convinced and confident that the information we now have adequately deals will all of the issues; in fact, this information is information provided by the hospitals themselves. I think, under those circumstances, this is the very best yardstick that one could ever devise.

I would urge, Senator, that on this issue you oppose retroactively applying the revised wage index as it would create a very unsettling reimbursement policy for the country. I think it would be very unwise to implement it retroactively.

Senator **Grassley**. At least prospectively you are satisfied that that will take care of some of the inequity, at least as far as it deals with just salary, wages, as part of the hospital costs?

Secretary **Heckler**. Yes.

Senator **Grassley**. You know, we will help in that direction. We still have to look for other costs within the hospital where there is probably an unfair treatment of rural hospitals that we will have to address, too, in other nonwage hearings. Obviously, I don't think those are going to be addressed in this package. But then, you are supportive of that wage index?

Secretary **Heckler**. Yes.

Senator **Grassley**. I would also like to ask, then, in a kind of special problem for hospitals outside of metropolitan areas, or rural hospitals located near urban areas, which receive substantially less than neighboring hospitals yet compete for the same labor maket and have the same costs as urban hospitals, does your agency intend to conduct research to create more accurate labor market definitions, particularly as it relates to those hospitals that are rural but still close to urban areas?

I don't know if that would be, in every instance, within an SMSA, either.

Secretary **Heckler**. As you know, the new urban/rural wage index deals with full-time and part-time employment and the actual costs of labor to a hospital in any section of the country. So, we now have a better yardstick.

In December, we will be submitting our report to Congress. It will be available on the whole urban/rural issue, and we will deal with the question you have raised in that report.

Senator **Grassley**. So, in December there will be some research already done, and it will be reported on in that December study?

Secretary **Heckler**. Yes.

Senator **Grassley**. Thank you.

The **Chairman**. Senator Bradley.

Senator **Bradley**. Thank you very much, Mr. Chairman.

I really want to make a comment. I don't have to ask Ms. Heckler any questions. But my comment relates to home care, which I know is a major interest of yours, Mr. Chairman. I remember we actually introduced a bill back in 1980, on home health care. Then the committee acted in 1981 on the Medicaid waiver, the Home and Community-Based Waiver Program, which we passed with the idea of giving States greater flexibility in trying to expand home care.

I am not the only one on this committee who has been interested in this issue. Obviously you have been. Senator Heinz has been and Senator Chafee has been. And it seems to me that we are all interested in this because there is a real need out there. We have to find some alternatives to institutionalization. Home care is clearly the direction that we have to head. I am sure those of us who have experience with DRG's now in operation in our States hear stories every day about the increased need for home care.

I must say that it is unfortunate that the administration has attempted to frustrate the intent of the 1981 act, as opposed to trying to promote health care and home care.

I might say that the chairman probably spent more time last year on negotiating with HCFA for the Oregon waiver than he did on a lot of other things; that is consistent with his own interest in this issue.

I won't take the committee's time to tell the New Jersey story on this issue, but I think many of us who care about it have fought to try to get waivers for the reason that we believe home care is an important alternative for the long term.

I introduced a bill not so long ago saying the States should have an option to run this program. And I am confronted with a kind of unusual response to the whole State option. I have OMB saying that the State option will produce expanded benefits and expanding, mushrooming costs for Medicaid, and therefore we can't afford it. That is OMB and HCFA's response.

Meanwhile, I have some colleagues in the House whose response to the State option concept is that if we give the States the option this will lead to much greater restrictions on the availability of home care.

So, I think that I and—from my discussions with the chairman and Senator Heinz and others who are interested in this—we find ourselves somewhere in the middle. And frankly, I am comfortable there, between those who say that it is going to mushroom in cost, and those who say it is going to reduce the program. And I really think the Finance Committee in working together can probably come up with some constructive action in this package on this very important issue.

And so, I hope that we will. And I say that without asking Mrs. Heckler what her view is, because I think that this committee really has that responsibility and that power, and I hope we will act.

Senator HEINZ. Would the Senator yield?

I simply want to associate myself with his statement.

Senator GRASSLEY. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Madam Secretary, I looked at that chart up there and can't be but impressed with the decline in the health care costs. And I think you are to be commended, as are a lot of other people in this country who have worked to control the increase in health care costs. It is obvious that there has been significant improvement.

The question, obviously, is what about the other side of the coin—quality? I regret that I was unable to be here for most of this hearing, but I am informed that earlier in the hearing you mentioned that your Department feels that the quality of health care has not declined.

Secretary HECKLER. Yes.

Senator BAUCUS. And that is particularly true, apparently, in the Department's view, for Medicare.

Could you tell me how the Department knows that the quality of health care has not declined, in view of the fact that costs have not increased as much as they have in the past?

Secretary HECKLER. Since the earlier Medicare law did not require any incentive for efficiency—since the cost-based reimbursement system ensured that any Medicare costs a hospital acquired would be passed on to HCFA and then paid—there was no reason for a hospital to examine all of its options for management and internal administration.

As a result, the cost of Medicare increased dramatically until the prospective payment system was enacted as part of the Social Security Amendments of 1983.

Without these incentives we found wide discrepancies in hospital reimbursement we studied across the country. For example, a hip replacement operation, which is very, very ordinary and quite common in every hospital, could cost $2,000 in one hospital, $9,000 in another.

Senator BAUCUS. Excuse me. I know what the DRG's are all about. We all know what DRG's are about. But my question is, what indicators do you have that show the quality of health care has not decreased, or that it has increased, over the last year?

Secretary HECKLER. Our best insurance in providing quality care and ensuring it is related to the peer review organizations which are mandated to review the quality of care as well as unnecessary admissions, unnecessary surgery, and the cost of care.

Senator BAUCUS. What criteria do you use, though, to indicate quality of care?

Secretary HECKLER. There are at least five different quality criteria, and the fiscal intermediaries as well as the peer review organizations assure the quality of care for the beneficiary.

For example, the fiscal intermediaries use medical record reviews, claims data, and consumer complaints, which identify quality problems. The cases involving poor quality are reviewed to the State survey agency, and sanctions are pursued when poor qualities of care are identified.

The carriers identify quality problems through the profiling of physician records review and consumer complaints. Cases, again, are reviewed to medical societies as well as the State reviewing agencies. And, in fact, among the criteria which have been established for the peer review organizations, the quality-of-care preservation issues are the most important criteria.

Senator BAUCUS. Well, as we move off into 1986, and as budget pressures are even more severe than they have been in the past, what indicators will the Department be looking at in order to determine whether the quality of health care has been maintained or whether it is declining? What indicators will the Department be looking at?

Secretary HECKLER. We have created a second insurance policy with a super peer review organization, which is now a consultant group that is reviewing at random the PRO's themselves. So, we will use those two instruments as, I believe, the best way of staying on top of the quality-of-care issue.

Senator BAUCUS. Now, what is the super peer review organization? What is that?

Secretary HECKLER. This is a consultant group that will review the peer review organizations' reviews. So that is a second review.

Senator BAUCUS. Who is on this super peer review?

Secretary HECKLER. This is a contract that has been given out by HCFA to a medical consultant firm, and they are going to create a second review team.

Senator BAUCUS. That oversees?

Secretary HECKLER. Yes.

Senator BAUCUS. This one super peer review will oversee all of those in the country?

Secretary HECKLER. No; they are going to do a random sampling of peer review operations across the country.

Senator BAUCUS. And this is the major vehicle you are using to determine whether or not the quality of health care is going to be maintained as we move into 1986?

Secretary HECKLER. Yes.

On June 17 we entered into a contract with Systemetrics, Inc., to validate medical review determinations made by the local PRO's. This review is called the super PRO. Systemetrics, Inc., will review a sample of 80,000 cases over a 2-year period, and this will be the basis for our judgments on the quality of care.

Senator BAUCUS. One quick question—I see my time is up. What about the Department's estimate of the percentage of physicians participating in Medicare in 1986? Do you expect the physician participation to drop next year, or not?

Secretary HECKLER. No; the figure for participating physicians who accept Medicare assignment 100 percent of the time is presently in the area of 30 percent.

Senator BAUCUS. Do you expect that to continue at 30 percent?

Secretary HECKLER. We would hope to have the number increase.

Senator BAUCUS. What are you doing to increase physician participation?

Secretary HECKLER. We have strongly supported the effort to encourage physicians to participate. We are working with the American Association of Retired Persons [AARP] in informing consumers as to their rights and the need to have them question their physicians as to whether or not he or she is a participating physician.

Senator BAUCUS. Well, I just hope you will look very hard at the quality side.

Secretary HECKLER. Yes, we are.

Senator BAUCUS. Obviously we have made some progress in getting health care costs to decline, or at least not to increase at the same rate as they have been. And it is incumbent on us to also look at the quality side. And I urge you very strongly to pay close attention to that.

Secretary HECKLER. I certainly agree with you, Senator.

Senator BAUCUS. Thank you.

The CHAIRMAN. Are there other questions?

[No response.]

The CHAIRMAN. If not, Madam Secretary, thank you very much.

Secretary HECKLER. Thank you.

The CHAIRMAN. Next we will have a panel of Dr. Monroe Gilmour and H. Rutherford Turnbull III.

Let me say to the other witnesses, it is my intention to work right through the lunch hour. And as opposed to Cabinet officials, who we do not put a time limit on, we do on other witnesses. Your entire statements will be in the record, but we will ask you to hold yourself to a 5-minute oral presentation, and we will take you in the order that you are on the witness list.

So, why don't you go right ahead, Dr. Gilmour?

STATEMENT OF MONROE GILMOUR, M.D., MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, CHARLOTTE, NC

Dr. GILMOUR. Thank you, Mr. Chairman.

My name is Dr. Monroe Gilmour, and I am serving as secretary of the American Association of Retired Persons, and am myself a retired cardiologist. With me is Mr. Martin Corry of the Federal section of the AARP. We do appreciate very much this opportunity of testifying before you today. And rather than try to summarize our entire statement, I would like to focus on several specific points.

First, regardless of whether the committee adopts a full or a selective freeze on payments to physicians, the association strongly urges the retention of certain provisions of the current freeze. We do so because it is imperative that those physicians who became participating physicians receive their promised update in Medicare fee screens. This update should encompass both the prevailing and the customary fee-screen.

Also, in order to protect beneficiaries, the freeze on actual charges by nonparticipating physicians, as well as current monitoring and compliance procedures, must be maintained.

Next, the additional incentives which complement financial incentives for physicians to participate should be continued, and the Department encouraged to improve their implementation.

Also, because final enactment of a reconciliation bill may extend beyond the expiration of the current freeze, we urge the committee to consider either some stopgap or other transition provisions.

Second, mainly, in order to prepare the groundwork for eventual reform of part B, we recommend that the committee establish a physician payment evaluation review commisison modeled after PROPAC, to review current policies and make recommendations for further interim reforms for the fiscal year 1987.

In addition, following the TEFRA precedent which led to enactment of the DRG's, we urge that you require the Secretary to develop and to submit to Congress by October 1, 1986, a legislative proposal for the development and implementation of a national Medicare relative value scale.

We also want to emphasize our support for the following measures:

AARP supports an appropriate second surgical opinion program for Medicare and Medicaid. Such a provision could save hundreds of millions of dollars by reducing practice variations, by improving the ability of peer review organizations to monitor quality and utilization, and by providing an improved and more flexible benefit to Medicare and Medicaid beneficiaries.

S. 1325, introduced by Senator Heinz, includes the elements of a workable second opinion program.

AARP urges the committee to address the continuing problem of State waivers for community-based care under Medicaid through legislation such as that proposed by Senator Bradley; but as a minimum, the modest improvements proposed in the House Energy and Commerce Committee bill.

AARP supports allowing doctors of optometry to become full providers under Medicare, but fully subject to their state practice laws.

AARP supports legislation to assure continuation for 2 or more years of private health insurance for widows, divorced spouses, Medicare-ineligible spouses, and their dependent children.

And finally, AARP supports extension of the current excise tax on cigarettes and recommends earmarking a portion of the generated revenue to the Medicare Program.

In conclusion, I wish to assure you that AARP stands ready to assist the committee as it undertakes this difficult task on reconciliation, and looks forward to working with you.

Mr. Chairman, I thank you.

The CHAIRMAN. Thank you, sir.

Mr. Turnbull.

[Dr. Gilmour's written testimony follows:]

STATEMENT OF DR. MONROE GILMOUR, AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons, appreciates this opportunity to testify on deficit reduction before the Committee today.

This Committee hardly needs another recitation of the current and potential effects of larger and larger deficits on the nation's economy and all its citizens, young and old. Suffice to say, these large and growing deficits propel us into uncharted waters, a course which is both risky and unnecessary.

Deficit Reduction and Older Americans

Older Americans have a major stake in the debate over the deficit and how it is reduced. Our members and volunteer leadership view the deficit as the chief economic concern of older persons. To ignore the deficit--to accept the status quo--threatens older persons just as much as some proposals to reduce it:

- Large deficits may harm the economy, and in turn programs on which the elderly rely, particularly the Social Security and Medicare trust funds, which are sensitive to economic fluctuations.
- A sour economy risks erosion of the elderly's purchasing power from other, nongovernment, sources of income--such as savings, pensions--just as surely as any budget cut.
- And, there is the family concern; our members don't want to see a huge debt passed to their children and grandchildren.

For these reasons, AARP and its members have consistently urged the President and the Congress to reduce the deficit, and supported responsible efforts to do so: TEFRA in 1982; the Deficit Reduction Act of 1984; and several Budget Resolutions in both Houses. We have supported these measures _not_ because they exempted older persons from additional burdens, but because, on balance, there was more good than ill, both on the tax and spending sides of the ledger.

Deficit Reduction Must Be Fair and Effective

But, just as we are concerned that the deficit be reduced, we are also concerned about _how_ it is done. In evaluating any deficit reduction measure we will look--as we have in the past--at whether, on balance, it is both fair and effective:

To be fair, a deficit reduction package must recognize the sacrifices made in previous budget reductions by various groups including the elderly. And, since no solution will be painless, how additional pain is distributed.

To be effective, it must address the two primary forces now driving up the deficit: the rapid increase in defense spending; and the huge drop in tax revenues precipitated by the excesses of the 1981 tax cut (for which there was bipartisan responsibility).

Since 1981, already enacted changes in spending and tax laws have dramatically changed the trends in federal fiscal policy. Any meaningful effort to reduce the deficit must recognize the effects of prior Congressional and Administration action.

On the spending side of the ledger, cuts in domestic programs reduced the cumulative deficits from FY 82 through FY 90 by over half a trillion dollars. (See Chart A) On the tax side, however, the effect of Congressional action on revenues has increased the deficit (FY82-90) by well over a trillion dollars. And, another $400 billion was added back in for defense spending.

Finally, the effect of all this red ink has added yet another $400 billion in interest costs to the cumulative deficits. As Chart B shows the effect of all of this has been to dramatically change the direction of federal policy: defense and interest costs are rising, while entitlements--including that great "uncontrollable" Social Security--are declining as is other domestic spending.

In short, effective deficit reduction must look not only at domestic spending, but also:

- Apply the same scrutiny to defense spending as has been applied to non-defense spending; and
- Restore the revenue base to a fiscally prudent level. The federal government provides subsidies on both the spending and tax sides of the budget. Over the past several years, the cutbacks have been primarily on the spending side while the giveaways have grown on the tax

side. In fact, five of the nation's largest corporations (General Electric, Boeing, Dow Chemical, Tenneco, and Santa Fe/Southern Pacific) paid no federal corporate income taxes at all over the last three years while generating profits of $13.1 billion. During the same period, they received $1.1 billion in tax rebates.

Budget Reconciliation in Medicare

Savings can be made on the domestic side of the budget. One area is health care. We can and should reduce the rising costs of health care. But such reductions should not be through cost-shifting which just changes the address on the bill and doesn't address the problem.

Under the First Concurrent Resolution on the FY '86 Budget, the Senate Finance Committee is called upon, once again, to achieve significant savings. And once again, much of it is assumed to come from the Medicare program.

Before commenting on some of the specific options before the Committee, the Association would like to outline the health care cost situation of beneficiaries.

Health Care Cost of the Aged

Medicare's coverage of health care needs, while adequate in certain areas, leaves the beneficiary at considerable risk in others. Overall, Medicare pays for less than half of the elderly person's total health care bill. And while Medicare covers about three-fourths of older persons' hospital bills, beneficiaires find themselves paying about 60% of their physician charges.

Beneficiary liability for medical bills assumes four different forms:

1. Cost-sharing (i.e., deductibles and coinsurance) associated with both Parts A and B of Medicare;

2. Unlimited charges associated with non-assigned physician claims;

3. Charges for non-covered services and products (i.e., long-term care, prescription drugs, eye-glasses, and basic dental services), as well as charges on all "covered services" once benefits have been exhausted; and,

4. Premiums for Part B and private health insurance coverage.

Out-of-pocket liability from these four categories is considerable and growing. The following examples are illustrative:

- In 1984, older Americans spent close to $10 billion to meet Medicare's cost-sharing requirements. This amount represents a 71% increase since 1981.
- In 1984, charges associated with non-assigned claims totalled $2.7 billion, representing a 300% increase in the last seven years.
- It is projected that by 1986 beneficiaries will spend nearly $12 billion out-of-pocket to pay for those

services and goods not covered by Medicare.

- Annual premiums for Part B coverage which currently total $186 have risen by 116% since 1977.

Beneficiaries now spend about 15% of their income on medical care, ironically, the same portion of their income as they spent prior to the establishment of the Medicare program. Further, even in the absence of any additional legislated increases in cost-sharing or premium amounts, elderly out-of-pocket expenditures for medical care will likely increase to 20% of income by the year 2000.

Increases in health care costs for elderly persons cannot be linked to excessive utilization of services. Indeed, for persons over 65, hospital admissions have increased only slightly over time, while average length of stay has dropped dramatically. Further, per capita physician visits by elderly persons have declined since 1974.

Reducing Medicare's Costs

While the Committee's immediate agenda is deficit reduction, AARP believes that additional criteria, rather than program savings alone, must be considered in evaluating any proposal to reduce Medicare outlays. First, any proposal to change Medicare must address the structural inefficiencies in the health care system rather than merely shift costs to beneficiaries and/or private payers of health care. Second, any proposal to change Medicare should improve the insurance status of the program rather than simply erode benefits for the Medicare population. Third, any proposal to change Medicare must prevent the development of a two-tier system of care. We urge the Committee to look not only at immediate savings attributed to particular options but also how such options would reduce costs by creating a more efficient health care system.

Finally, AARP believes that Congress should begin now to implement long-term reform in the Medicare Part B program. We urge the Committee to take some initial steps toward reform of Part B for the following reasons:

- o The establishment of the DRG system for Medicare hospital payment will continue to shift care from the inpatient to outpatient setting. If nothing is done to reform Part B, the move towards outpatient care will exacerbate Part B's current spending problems. In addition, beneficiaries' out-of-pocket costs will significantly increase since coverage under Part B is less comprehensive than coverage under Part A.
- o Even with the enactment of last year's freeze on Medicare payments to physicians, Medicare Part B expenditures will continue to rise at an annual rate of increase of 16 percent. This rapid rate of increase often leads policy-makers to look for program cuts based upon program savings alone rather than ways to create efficiencies in Part B which would benefit both providers and beneficiaries;

- Whether the current Medicare physician fee freeze expires this October or next, it is timely to consider what steps can be taken when the freeze expires to rectify well-documented problems and discrepancies in Medicare's current physician payment methods.

Our testimony today will suggest several measures which produce budget savings, create greater efficiency in Part B financing and benefits, and move the system in the direction of long-term reform.

Physician Reimbursement

It is generally understood that Medicare's physician reimbursement system which is based upon what physicians customarily charge each year (the CPR methodology) has led to over-inflation of physician expenditures by encouraging both price and volume increases. For example, between 1980 and 1982, Medicare expenditures for physician services rose by over 20 percent per year. Much of this incresae stems from the fact that prices for physician services have outpaced general inflation and because of increasing intensity of services (the number of services per enrollee), which accounted for nearly 40 percent of the growth in program costs over this time period. It is important to note, however, that on a per capita basis, visits to physicians by beneficiaries has declined since 1974.

Moreover, the CPR methodology has generated numerous discrepancies and anomalies in physician payment such as:

- The gap in compensation for the use of technology and procedures versus cognitive services;
- Differentials in reimbursement--not all of which may be warranted--by specialty, place of service, and geographic location;
- The presence of payment incentives that discourage the treatment of the sickest and frailest segments of the population;
- The presence of payment incentives that encourage the use of expensive hospital care over less costly office-based care.

Last year Congress took an important first step towards addressing the complex problem of rising physician fees when it enacted the Medicare physician fee freeze. AARP believes that Congress should build upon this initiative and this year enact legislation which would serve as the basis for the institution of a more rational physician payment methodology. Failure to begin now is likely to mean year after year of arbitrary budget actions which will further erode the purposes of Medicare and its acceptability to beneficiaries and physicians alike.

AARP believes that no one payment methodology (DRGs, fee schedules, capitation, etc.) will be appropriate for all types of physician services. While AARP does not endorse at this time a particular mix of payment mechanisms, AARP would like to suggest a legislative package which would produce budget savings, begin to redress current inequities in Medicare physician payment, and move the current payment system towards long-term reform.

1. Rather than extend the current fee freeze to all physician services, apply a freeze to all Part B physician services except office, nursing home, and home visits. (Estimated savings: $1.2 billion over three years).

Because reimbursement is based on historical charges, Medicare reimbursement for physicians has under-valued office-based care compared to hospital-based care. A study by Hsaio and Stason found that office-based care has been paid at hourly rates of only one-fourth to one-fifth the hourly rate for surgical procedures. In 1982 Medicare's prevailing charge for hospital visits averaged 18-32 percent higher than for office visits. A higher rate of increase in Medicare fees for office, nursing home, and home visits would begin to redress this payment discrepancy between hospital-based care and office-based care. Moreover, a selective freeze targeting hosptial-based care would be consistent with policy reforms already initiated by Congress to reduce unnecessary hospitalization.

2. Establish a Physician Payment Evaluation Review Commission, modeled after PROPAC, to review current policies and make recommendations for further interim reforms in FY '87. Areas to be reviewed could include:

- the identification of those procedures (e.g. surgical) for which current charges may be overvalued and recommending reductions as well as the identification of those services (e.g. cognitive services) for which charges may be undervalued and recommending increases;
- the identification of unwarranted variations by geography, specialty, and place of service, and recommending steps to correct these variations;
- the renewal of the participating physician program and recommending ways to expand it and increase the assignment rate by non-participating physicians;
- the review of variations in use of assistants at surgery and recommending procedures governing the use of these assistants; and
- the review of forthcoming reports on options for Medicare physician payment such as the current study by the Office of Technology Assessment and the study on the feasibility of MDDRGs by the Health Care Financing Administration.

3. Following the TEFRA precedent which led to enactment of DRGs, require the Secretary to develop and submit to Congress a legislative proposal for the development and implementation, of a national Medicare relative value scale, beginning in 1987. Such a proposal would:

- establish a national set of physician services and assign relative values or weights to those services; and
- develop a standard methodology for converting the

relative values or weights to a prospectively-determined schedule of allowances.

The proposal should also include a timetable for transition to the new payment rates, a methodology for regular recalibration, and an allowance for geographic variations in cost-of-living.

Extension of the Current Freeze

Regardless of whether the Committee adopts a full or--as we recommend above--a selective freeze the Association strongly urges the retention of certain provisions of the current freeze:

- The current fee freeze allowed physicians to choose a "participating" (accept assignment in all cases) and "non-participating (accept assignment on a case by case basis) option. As an incentive, "participating" physicians were allowed to pass along higher charges to be added to their record during the freeze period in order to recieve more generous Medicare reimbursement when the freeze expired. Thirty percent of physicians have elected to become "participating" under the current freeze, a 10% percentage point (or 50%) increase over the previous 20% who accepted assignment in all cases. It is imperative that those physicians who became "participating" physicians receive their promised update in Medicare fee screens. This update should encompass both the prevailing and customary fee screens of participating physicians. If only the customary fee screens of participating physicians are increased, those participating physicians whose customary charges exceed prevailing charges would not receive their promised update.

- In order to prevent cost shifting to beneficiaries during the current freeze on Medicare payments, the Deficit Reduction Act of 1984 also provided for a freeze on actual charges by non-participating physicians, as well as monitoring and compliance procedures. We strongly urge the maintenance of such provisions, without which beneficiaries would be subject to higher our-of-pocket costs.
- The current freeze also provides for a number of additional incentives which compliment the financial incentives for physicians to "participate." Because the current freeze and its attendent provisions were crafted and implemented on a very short schedule, not all worked well during the past year. Nonetheless, they should be continued and the Department encouraged to improve their implementation.
- Finally, because final enactment of a reconcilation bill may extend beyond the expiration of the current freeze and its accompanying provisions, we urge the Committee to consider either some stop-gap measures or other transition provisions. Already, this has become an issue as the Department is sending out letters to physicians,

through their carriers, without crucial information on the liklihood of a freeze and any financial incentives to become or continue as a "participating" physician.

Second Surgical Opinion Programs

Over the past decade or so we have learned a great deal about how health care providers practice in this country. We know, for example, that the United States has the highest rate of surgery in the world and the highest ratio of surgeons to population in the world. Thus, it should not be surprising that the rate of elective surgery in the United States is increasing 3-4 times faster than the growth in the population.

We know, too, that a great deal of surgery being performed is inappropriate and unnecessary. Though there have been many whose research elucidates this problem, the work of Dr. John Wennberg on small area variations in physician practices clearly shows that unnecessary surgery occurs on a regular basis. Moreover, his analysis of the DRG categories shows that there is a huge amount of practice variation within each DRG. If those variations are not appropriately reduced, policymakers will miss the most important opportunity for achieving meaningful savings in the Medicare program.

AARP believes that an appropriate second surgical opinion program (SSOP) for Medicare and Medicaid could save hundreds of millions of dolars by reducing practice variations, improving the ability of peer review organizations to monitor quality and utilization, and providing an improved and more flexible benefit to Medicare and Medicaid beneficiaires. The elements necessary for a workable and successful second opinion program are specified in S. 1325, introduced by Senator Heinz and H.R. 2807 introduced by Representative Kennelly.

During a time of severe program cuts and huge federal deficits, a second surgical opinion program for Medicare and Medicaid offers a rare opportunity to save money, and improve the quality of health care at the same time.

Vision Care

AARP supports allowing doctors of optometry to become full providers under Medicare, subject to their state practice laws (as provided in the House Energy and Commerce Committee's bill).

Medicare Part B currently covers certain eye and vision care services when provided by doctors of medicine or osteopathy, but not when these same services are provided by doctors of optometry. Consequently, Medicare beneficiaries who choose a doctor of optometry for their vision care, either because they have always gone to that provider or there are no doctors of medicine or osteopathy readily accessible, must pay out-of-pocket for services which are essentially covered services. Correcting this payment discrepancy, would improve the availability and accessibility of vision care benefits under Medicare.

This provision would result in slightly higher program costs ($155 million over years). However, this cost could be offset by adoption of mandatory 2nd surgical opinion program in Medicare, proposed above.

Medicaid Waivers

AARP is deeply concerned about the development of home and community based alternatives to institutionally based long term care (LTC). The aging of the population, longer life spans and a host of other significant demographic trends underscore the need to develop less costly alternatives to institutional nursing home care.

The Omnibus Budget Reconciliation Act of 1981 (OBRA) provides states an opportunity to develop home and community based LTC alternatives. Under Section 2176 of OBRA, the federal government can waive certain Medicaid program requirements to encourage states to develop home and community based LTC services. The program is very popular among the states despite the great difficulty states have had in receiving 2176 waivers from the Health Care Financing Administration. Because of these difficulties and the Administration's narrow view of the enabling legislation, AARP supports S. 1277, sponsored by Senator Bradley to eliminate the necessity of a waiver to provide the services currently available only under the waiver. Like Senator Bradley, AARP believes that these services should be available at the discretion of the states.

Short of making the waiver services another option at states' discrection, AARP believes the Congress should modify through legislation the unnecessarily strict regulations deterring the

2176 waiver program. These regulations do not provide needed flexibility to the states to develop home and community based alternatives to institutional care.

For example, HCFA limits the number of people who can be served under a waiver to the number of nursing home beds to be built in the state. Such a measure rewards states that have not controlled nursing home construction and penalizes states that have had such controls--the very states most in need of home and community based alternatives. This perverse result is clearly not Congressional intent regarding the waiver authority. Rather than encouraging states to increase bed growth, the waiver authority was aimed at giving states a method to slow or even stop bed growth while providing a more appropriate alternative to nursing home care.

The House Committee on Energy and Commerce budget reconciliation package, H.R. 3101, makes several positive adjustments to the current waiver process. AARP believes these are small, but important improvements and commends them to the Committee for its consideration. In addition, ARP would welcome opportunities to work with the Committee on the devleopment of further measures to improve the 2176 waiver process.

Excise Tax on Tobacco Products

The increased incidences of certain diseases among users of tobacco products provide medical evidence of a high correlation between the use of tobacco products and increased health care costs. In 1981, the total health and economic costs associated with tobacco use was estimated to be nearly $4 billion. Despite this evidence, the federal excise tax on cigarettes has been raised only once since its imposition in 1951 with this increase scheduled to expire October, 1985. Extension of the increase would generate substantial revenues for the federal government.

AARP supports extention of the current excise tax on cigarettes and recommends earmarking a portion of the generated revenue to the Medicare program. Since heavy users of tobacco products use a significant share of Medicare resources, it is fair to ask them to help defray Medicare's costs.

Mandatory Medicare Coverage For State and Local Employees

AARP supports mandatory coverage of current state and local government employes under the HI program. Mandatory Medicare coverage of these employees would increase fairness in the program, improve health coverage for those state and local employees who never gain Medicare coverage, and raise significant revenues ($6.3 billion over three years) for the ailing HI Trust fund.

Eighty-five to ninety percent of these employees eventually become eligible for Medicare even though they may have contributed very little to the system. Consequently, these employees who receive full Medicare coverage but do not pay the HI tax for their entire working careers are unfairly subsidized by other retirees who have worked under Social Security and paid the HI tax their entire working career. Imposing the HI tax on state and local employees woule redress this ineqity.

Extending the HI tax to state and local employees would likely improve health coverage for retired state and local employees. Evidence exists that Medicare provides more comprehensive health insruance coverage than state and local plans can afford to provide their retirees. Moreover, Medicare coverage is portable. State and local employees who change jobs and would lose eligiblity for benefits under state and local plans would find Medicare coverage advantageous.

Coverage of State and Local Government Employees Under Social Security

AARP supports universal Social Security coverage. But, the Association also recognizes that retirees/workers who are not covered by Social Security must be protected from precipitous changes which endanger their existing retirement systems.

Currently, 70 percent of all state and local employees are already covered by Social Security. The move to include new state and local employees who would not otherwise be covered makes sense for the following reasons: 1) some local retirement systems do not provide coverage that is comparable to Social Security (e.g. disability coverage, survivor benefits, inflation protection, portability); 2) many employees starting in public employment now will work some years in Social Security-covered employment; and 3) including new state and local employees raises revenue at a time when the Social Security system, while sound, does not have substantial surpluses.

While AARP thinks that including new state and local employees is good public policy, the Association also believes that this move must not endanger in any way existing state and local retirement systems. Changes made to accommodate the new employee inclusion in Social Security must be phased-in and ensure a secure stream of income for state and local systems which are not fully funded.

In addition, AARP supports national fiduciary, reporting and disclosure standards for primary state and local systems.

Private Health Insurance Continuation

AARP supports the provision adopted by the House Ways and Means Committee to deny the business tax deduction for a group health plan to any employer who fails to include a continuation option for widows, divorced spouses and Medicare ineligible spouses, and their dependent children. Although not a total solution to the growing number of Americans without health insurance, this provision will substantially improve continued access to affordable health insurance coverage for a significant number of these individuals. In order to fully evaluate the impact of this continuation option on the accessibility of health care coverage, AARP believes that this provision should continue for a period of several years.

Conclusion

In conclusion, AARP appreciates the opportunity to offer our views on deficit reduction, and stands ready to be of assistance to the Committee as it carries out its responsibilities.

Chart A

INCREASE IN THE DEFICIT ATTRIBUTABLE TO CONGRESSIONAL POLICY ACTION

(Fiscal Years; Billions of Dollars)

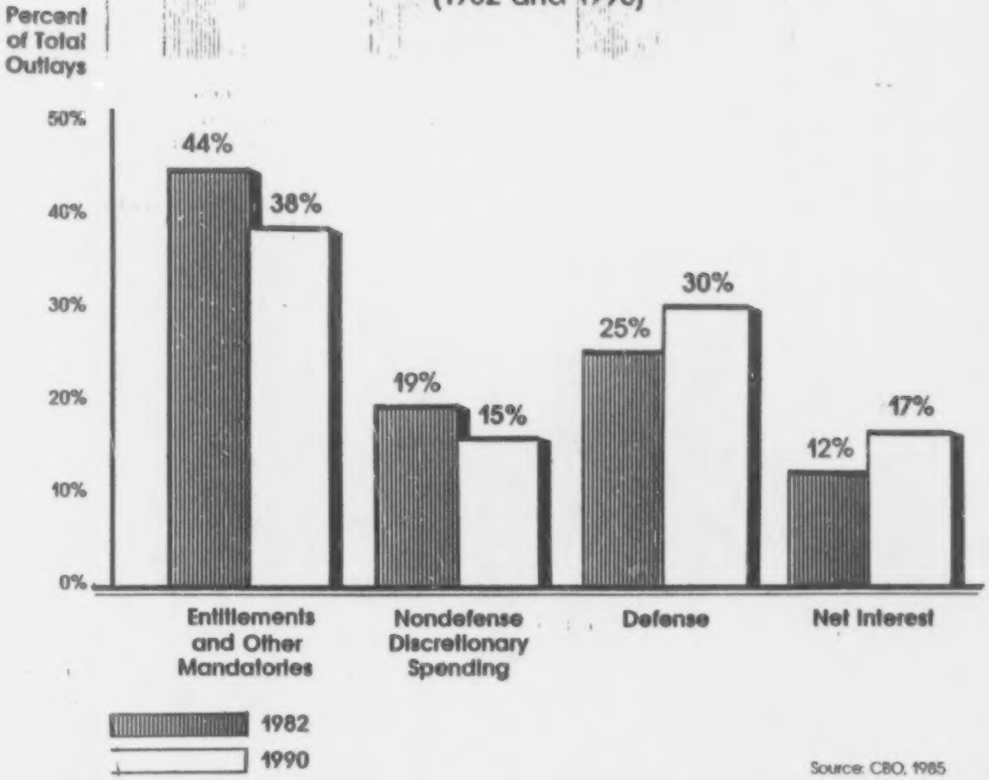
	1982	1983	1984	1985	1986	1987	1988	1989	1990	TOTAL
Legislative Changes										
Tax reductions	-41	-75	-99	-111	-130	-149	-162	-186	-228	–1181
Defense spending increases	-3	-16	-23	-35	-41	-53	-65	-79	-95	– 410
Nondefense spending cuts	40	48	50	38	63	69	73	82	88	+ 551
Effect of legislative actions on interest costs	a/	-3	-10	-21	-35	-50	-69	-93	-123	– 404
Total changes	-5	-45	-81	-129	-143	-183	-223	-276	-359	–1444

SOURCE: Congressional Budget Office.

CHART B

COMPOSITION OF OUTLAYS IN THE FEDERAL BUDGET

(1982 and 1990)



Source: CBO, 1985

STATEMENT OF H. RUTHERFORD TURNBULL III, PRESIDENT, AMERICAN ASSOCIATION ON MENTAL DIFICIENCY; ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Mr. TURNBULL. Mr. Chairman, I am Rutherford Turnbull of the University of Kansas. I am a parent of a disabled child. I am the president of the American Association on Mental Deficiency, and I represent the Consortium for Citizens with Developmental Disabilities.

The time has come, and it is now, for this committee and for the Congress to fundamentally restructure title XIX of Medicaid as it applies to people with disabilities. The time is now for this committee and for the Congress to reverse the very assumptions on which that legislation is built. That bill assumes the institutional model is preferable to the community model. That is wrong. It assumes that the medical model applies to all people with disibilities. And that is wrong. It assumes that permanency of care can be best provided in institutuions. And we think that is wrong. It assumes that people with disabilities cannot adjust in communities and that communities will be hostile to them. And we think that is wrong.

The time is now for Congress to declare that the norms and the forms of this society and of the Medicaid policy that reflect it are wrong. The data show it; the professional organizations know it; the consumer organizations know it; and many Members of this Congress know it, too.

If you will, title XIX as it is presently in law is the Sargent York of Federal policy having to do with people with developmental disabilities.

I would like to draw your attention to some options that are before you. On a short-term basis, and picking up what Senator Bradley and Senator Heinz have noted already, Congress may deal with five problems. These problems arise from the very fact that HCFA has attempted to subvert the congressional intent.

HCFA sees title XIX as a way to cut the costs of long-term care, not, as you intended, for them to be a way to control the costs and also to expand the services. Senator Bradley himself has talked just a few moments ago about the need to expand home care and that being the intent of the 1981 amendments.

We propose five specific ways in which the Congress now may act. In three of those the House has already acted, in H.R. 3101. In two other ways this committee may and should act.

Indeed, I want to pick up on Senator Mitchell's comments about the Life Safety Codes. We find the response by the Secretary to be inadequate, frankly. She says, upon second questioning, that it may be desirable for separate regulations to be issued for the Life Safety Code for people in ICF/MR facilities.

We would prefer the Congress to command the adoption of those 1985 Life Safety Codes.

The three other actions by the House in H.R. 3101 seem to us to be very sound, and we strongly recommend them to you, with one minor change in one respect.

There are some short-term options. If the committee and the Congress adoptes those options it will have three effects, and they are important:

First, it would restore to the title XIX waiver predictability and stability. The way that the administration has operated under the waiver creates instability and unpredictability.

Second, it would reestablish the congressional intent, which was not to cut costs but to contain costs and to make services available within the containment to more people.

And third, it would lay the foundation for fundamental restructuring of the Medicaid provisions. And it is to that that I now address you.

Long term and we hope in this session of the Congress, we can either change the presumptions—the present presumption is in favor of institutional care—with a rebuttable presumption in favor of the community, or we can make the home-based care an option, as Seantor Bradley's bill does, or we can create a new presumption as Senator Chafee's bill does which is in favor of the community.

It seems to us that the old presumption in favor of institutions with a rebuttable presumption in favor of the community is dead wrong, and that either one of those other options are strongly recommended to you.

We are at a threshold, and I think this committee is in a position to do something on a short-term basis and, within this session, to do something on a long-term basis about this issue.

Thank you, Mr. Packwood. Thank you, Senators.

[Mr. Turnbull's written testimony follows:]

STATEMENT BY H. RUTHERFORD TURNBULL III, ESQ., F.A.A.M.D., PRESIDENT, AMERICAN ASSOCIATION ON MENTAL DEFICIENCY ON BEHALF OF CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

I. STATEMENT OF INTEREST

A. Consortium for Citizens with Developmental Disabilities

The Consortium for Citizens with Developmental Disabilities (CCDD) is a working coalition of national professional, consumer, and provider organizations that advocate on behalf of persons with developmental disabilities. CCDD was founded in 1973 and since that time has served as a forthright voice for the interests of citizens with mental and physical disabilities within the halls of Congress and among Executive Branch agencies. Over the years, the number of CCDD affiliated organizations has steadily increased. At present, there are over forty national groups that are members of the Consortium.

The CCDD Task Force on Medicaid is interested specifically in those aspects of the federal-state Medicaid Assistance program which impact on the capability of states and private providers to furnish appropriate, high quality services to Title XIX-eligible children and adults with developmental disabilities. As such, fifteen organizations represented on the Task Force are vitally concerned with the provision of home and community-based services to persons with mental retardation and other developmental disabilities under waivers approved by the Secretary in accordance with the provisions of Section 1915(c) of the Social Security Act.

B. Witness

The following testimony to the Senate Finance Committee is presented on behalf of the Consortium for Citizens with Developmental Disabilities (CCDD), by H. Rutherford Turnbull, III. Mr. Turnbull is President, American Association on Mental Deficiency, the nation's oldest and largest interdisciplinary professional organization in the field of mental retardation and developmental disabilities; the father of an 18-year old son whose mental retardation will qualify him as a recipient of Medicaid services; a professor of special education and law, The University of Kansas, whose work includes public policy in disabilities; and a member of the Association for Retarded Citizens--United States, which he served as National Secretary for two years (1981-1983). Both AAMD and ARC-US are members of the CCDD.

II. THE NEED FOR FUNDAMENTAL MEDICAID REFORM: REVERSING ASSUMPTIONS

Although the immediate focus of this Committee is on the Budget Reconciliation process and the need to enforce budget reducations, members of the Committee and of the Senate as a whole know of the pressing and immediate need to address long-term care involving people who are mentally retarded and otherwise developmentally disabled. What it does this year therefore should lay the foundation for humane and fiscally sound policy that will be reflected in major revision of Medicaid and other federal policy.

From my work with professionals and their organizations and with consumers and their organizations, from my close associations with families whose children are retarded and otherwise developmentally disabled, and from my research and that of my colleagues at The University of Kansas and elsewhere, I am convinced that the Home and Community Based Care waiver was necessary but not wholly sufficient policy. My colleagues in CCDD are of the same opinion.

The time has come to reform the Medicaid program in a significant way. That time may begin in the few months that are left to Congress to enact the Budget Reconciliation Act. But if not this year, the time will be in the next session.

What should Congress do? First, it should continue the direction the House has set in H.R. 3101. Specific action is suggested in this testimony.

More than that, however, Congress should fundamentally restructure the Medicaid legislation as it affects people who are mentally retarded or otherwise developmentally disabled, and their families, by reversing the very premises of that legislation. Instead of looking to institutional care as the principal system for providing services, Congress should look to home and community as the principal system. Instead of looking to the medical model as suitable for all people who are mentally retarded or otherwise developmentally disabled, it should adopt the developmental model. Instead of creating permanency of care in institutions, it should create permanency of care in the home and community by directing Medicaid funds towards home and community. Instead of having federal policy rest on out-dated knowledge about the supposed lack of ability of people who are disabled, it should have policy rest on the current knowledge that all people who are disabled, no matter how disabled they are, can be suitably accommodated in community-based education, habilitation, and medical service-delivery systems, and that they achieve greater development there than in institutional programs. Instead of having policy rest on the assumption that the community will be hostile to people with disabilities, it should fashion policy that recognizes that people with disabilities make good community citizens and, more often than not, are welcomed into communities once they have been given the chance to be in communities. The only way to eradicate prejudice is to give the prejudiced the opportunity to know the objects of their prejudice. In short, instead of having the norms and forms of federal policy, and therefore the norms and forms of society, rest on the exceptional and unusual, it should take the occasion of long-term care review to have federal policy, particularly in Medicaid, rest on the ordinary and usual, on home and community.

This is the message that I hear from most professionals, consumers, providers, and, most importantly, families and people who themselves are disabled. It also is the most salient implication of current knowledge and my own research.

Allow me now to address the issue directly before this Committee--the opportunity to continue in that direction by reforming the HCBC provision of Medicaid.

III. BACKGROUND

Nearly four years ago, Congresss added a new provision to Title XIX of the Social Security Act (Section 1915(c)), as part of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). This new subsection was designed to permit states, under certain circumstances, to furnish Medicaid reimbursable home and community care services to eligible recipients who otherwise would require long-term care in Medicaid-certified facilities. Before the enactment of this legislation, only very limited coverage of non-institutional long-term care services was available under the Medicaid plans of most states.

During the 3½ years that have passed since the Department of Health and Human Services issued its initial regulations implementing the HCBC waiver program, the number of participating states and approved waiver rquests has increased dramatically. As of June 15, 1985, HCFA officials report that a total of 106 waiver requests, from 46 states, had been approved. Of this total, approximately 40 percent are intended (in whole or in part) to furnish specialized community-based services for recipients with mental retardation and other developmental disabilities. The total number of recipients now participating in waiver-financed programs has been estimated at over 50,000.

The response of consumers, providers and state officials to the HCBC waiver program clearly indicates that Congress struck a responsive chord when it decided to grant the states increased flexibility to address the long-term care needs of low income citizens who are elderly or disabled. However, as members of the Senate Finance Committee will learn during these budget reconciliation hearings, the promise of the Medicaid home and community care waiver program is being undermined by fiscally motivated policies of the Administration.

The Committee will receive testimony regarding the benefits derived by participants in HCBC waiver programs, as well as the administrative problems which states have encountered in attempting to obtain approval and operate such waiver programs in the face of continuing uncertainty regarding applicable federal policies. Therefore, I will focus my comments on: (a) the fundamental statutory issues that must be addressed in order to assure future stability and predictability in funding for home and community-based alternatives to institutional care under the federal-state Medical Assistance program; and (b) proposed statutory amendments to achieve this objective.

IV. PROBLEMS SURROUNDING THE OPERATION OF THE SECTION 1915(c) WAIVER PROGRAM

One key to understanding the present controversy regarding the operation of the HCBC waiver program is that all of the issues lead back to one underlying reality: there are significant differences of opinion concerning the intent of Congress in authorizing the program. It is important to remember that the home and community care waiver program was enacted as part of legislation designed to limit future federal outlays for social programs. Not surprisingly, the Administration saw this new authority as primarily a cost-cutting device, while others, including many members of Congress, state officials, and professional associations and consumer advocates, emphasized the legislation's humanistic goal of maintaining frail elderly and persons with disabilities in more appropriate home or community care settings.

The provisions of the 1981 legislation reflected this sense of Congressional ambivalence. Concern about the financial consequences of offering Medicaid reimbursement for home and community-based services was clearly evident in the requirement that requesting states demonstrate that the average per capita cost of services with the waiver would not exceed comparable per capita costs without the waiver. But, Congress also elected to allow states to cover recipients who were at-risk of institutionalization as well as those currently residing in Title XIX-certified institutions, thus implicitly recognizing that demand (and, consequently, Medicaid costs) for nursing home beds and other forms of institutional care were likely to be lower if a state were able to offer persons at-risk of institutionalization home and community-based alternatives.

In providing this option, however, Congress left to administrative interpretation the methods of determining the number and types of potentially eligible recipients who could be said to be at-risk of institutionalization and, thus, eligible for waiver-financed services.

Initially, the Health Care Financing Administration (HCFA) published interim final regulations which included a mathematical formula for determining the cost effectiveness of a state's proposed waiver program. These regulations contained no explicit limitations on the number or types of waiver recipients a state could plan to serve, except that the requesting state had to spell out the procedures it would use to determine that all applicants for waiver services were assessed and found to be in need of institutional care in a Title XIX-certified facility. After receiving expansive waiver requests from several states, however, HCFA and OMB officials began to worry about the cost implications of the program and soon instituted review procedures that had the effect of restricting the number and types of recipients a state could cover under an approved waiver program. By and large, these procedures are codified in the final waiver regulations published by HHS on March 13, 1985 (Federal Register, Vol. 50, No. 49, p. 10013). Let us illustrate some of the inequities caused by these HCFA review procedures.

A. Limitations on the Number of Eligible Recipients

HCFA officials require a state to furnish detailed documentation regarding the current number of Medicaid-certified beds in SNFs, ICFs and ICF/MRs, along with evidence of the need for additional bed capacity in the absence of a waiver. In cases where the proposed waiver population would exceed the capacity of present Medicaid-certified beds, a state is obligated to produce convincing evidence that new facilities in fact would be constructed and certified in the absence of the proposed waiver (e.g., approved certificate-of-need requests; capital appropriations for new/expanded facilities, etc.). States also must furnish data on: a) the occupancy rate of Medicaid-certified SNF, ICF, and ICF/MR beds, by type, including any excess bed capacity, by type; b) waiting lists for admission to certified facilities, by type; and c) the number of waiver clients actually being deinstitutionalized versus those diverted from admission.

HCFA officials use this data to establish whether a state plans to serve more recipients (i.e., in both institutional and noninstitutional settings) with vs. without the requested waiver program. If the state projects any significant differential growth in the total number of recipients of long-term care services with the waiver, HCFA officials generally will refuse to approve the request.

This method of restricting eligibility for waiver services has a number of side effects which subvert the original intent of Congress. The Congressional intent was to provide more appropriate community services at not more than the cost of institutional services. It was not to save money, as HCFA seems to think by its ultra vires interpretation and policies.

First, states are effectively precluded from reinvesting any savings that may be associated with providing services in home or community-based vs.

institutional settings into expanded diversionary services. While Congress intended to restrict waiver services to client populations that, on average, could be served at no greater cost in the community than in Title XIX certified institutions, Congress did not seem to want to prevent states from using program savings to serve a larger number of eligible recipients.

Second, by, in effect, placing numerical limits on the number of waiver recipients, HCFA offers the states powerful incentives to restrict services to those recipients who require the most extensive (and costly) array of community-based services. It is worth noting, for example, that few states have elected to offer family assistance and other high volume, low cost services under approved MR/DD waiver programs, despite an almost universal recognition of the pressing need and long-term cost effectiveness of such programs. Instead, states, knowing that they will be allowed to serve only a finite number of recipients, choose to offer waiver services to clients requiring both an out-of-home living arrangement and a full time day habilitation program. This approach not only perpetuates a one-size-fits-all approach to long-term care services, but also contradicts the Administration's own commitment to strengthening the nuclear family.

Third, states which have a relatively low per capita rate of institutionalization, either due to prior deinstitutionalization efforts or policies discouraging the establishment of new institutional beds (e.g., a moratorium on the certification of additional Title XIX LTC beds), are significantly disadvantaged by HCFA's methodology of calculating projected institutional capacity and, thus, the number of recipients that the state may qualify for waiver services. National statistics indicate that there are striking state-to-state variations in the number of SNF, ICF and ICF/MR beds and, by extension, demand for home and community-based servicesa. Yet, HCFA does not take these differences into account in calculating a state's current and future demand for long-term care services. Similarly, HCFA ignores interstate differences in projected population growth, even though Census Bureau figures indicate that some states can expect a growth rate several times the national average and, thus, are likely to face a disproprortionate increase in demand for LTC services.

Finally, HCFA's methodology emphasizes the immediate fiscal consequences, rather than the long range cost implications, of waiver expenditures. This policy will prove to be "penny wise and pound foolish." Under present policies, states which originally planned to use the waiver authority to mount a comprehensive diversionary program will be forced to expand the capacity of nursing homes and other Title XIX-certified institutions. The net result will be steeper growth in federal-state Medicaid expenditures for LTC services than otherwise would be the case. Already, for example, states that have been permitted to only cover a limited number of recipients under their MR/DD related waiver programs now resolve their problems by dusting off plans to certify more ICF/MR beds to meet the need for community-based services. These beds will be considerably more costly to operate than waiver-financed HCBC services.

One brief example will help to illustrate the arbitrary effects of HCFA's current review process. Under its original Section 2176 waiver program for persons with developmental disabilities, approved in 1982, the State of Florida was permitted to serve an average monthly caseload of 6,665 clients. Because a strong emphasis was placed on supporting families who were caring for offspring with severe disabilities at home, the State was able to offer services to eight waiver recipients for every one who was receiving services in a Title XIX-certified institution.

When Florida submitted its waiver renewal request earlier this year, it asked permission to cover an average monthly caseload of 7,800 clients. HCFA responded that, according to its calculations, the state could cover 43 recipients, a number equal to the excess bed capacity in the State's ICF/MR-certified facilities! Although the State was able to demonstrate that it had sharply reduced the number of institutional beds (from 6,107 in 1970 to 2,200 in 1985), had one of the lowest per capita rates of institutionalization in the country, and had over 9,000 clients with severe developmental disabilities who required services, HCFA would not agree to approve the state's waiver request. Finally, after months of negotiations and hundreds of hours of staff time, HCFA eventually agreed to allow the State to provide services to a maximum of 2,300 eligible clients under its renewed waiver program. State officials, however, have indicated that they will reorient the program to focus on high-cost clients. Consequently, the total federal cost of waiver services will be approximately the same as in year three of the old program, even though 65 percent fewer recipients will receive services.

B. Limitations on Covered Services

At present, there is a considerable amount of ambiguity surrounding HCFA's interpretation of legitimate claims for habilitation services rendered to recipients with developmental disabilities under an approved HCBC waiver program. In the preamble to the recently issued final waiver regulations (March 13, 1985), HCFA states flatly that prevocational/vocational training and educational activities are not reimbursable under a home and community care waiver. In explaining the rationale for this interpretation, the preamble indicates that:

> ...qualifing services under Section 1915(c) of the Act must be directly related to the ultimate goal of the home and community-based services;

> that is, enabling the recipients to accomplish those day-to-day tasks necessary for them to remain in the community and avoid institutionalization. We do not believe that prevocational and vocational training and education activities are commonly furnished as a means of avoiding institutionalization. Individuals would not, in the absence of such services, require institutionalization. Therefore, in applying our regulations, which define home and community-based services, we have interpreted Section 440.180 as excluding these services because they are not cost effective alternatives to institutionalization (*Federal Register*, March 13, 1985, Vol. 50, No. 49, p. 10020).

There are several observations that should be made concerning HCFA's interpretation. First, HCFA has never indicated how it expects the states to distinguish between habilitation, education, and vocational (or prevocational) training for purposes of Medicaid reimbursement. Yet, waiver requests from several states have been disapproved, in part, on the grounds that one or more of the proposed services constituted nonallowable vocational or prevocational training (e.g., Tennessee and Louisiana). A number of other states also have been required to modify their definitions of covered services in order to obtain HCFA approval (e.g., Colorado, Delaware, and North Dakota).

The difficulty in drawing such distinctions is illustrated by the recent dispute between the HHS Inspector General and some twenty states over proposed disallowances for allegedly erroneous educational and vocational training claims in ICF/MR facilities. In the absence of clarifying statutory or Congressional report language, it is likely that waiver-eligible clients will continue to be denied habilitation services on the grounds that such services are educationally or vocationally oriented.

Second, on a purely factual basis, HCFA's statement that educational, prevocational, and vocational services are not "commonly furnished as a means of avoiding institutionalization" is simply wrong. Study after study has found that access to appropriate day services (including educational and prevocational/vocational training) is an absolutely essential prerequisite to successfully serving persons with developmental disabilities in community settings. These services (particularly prevocational, vocational, and educational programs) prevent institutionalization by providing the training necessary for community living. Indeed, to our knowledge, there is not a state MR/DD agency in the country that does not mandate access to an appropriate day program as a precondition to receiving community residential services.

Finally, it makes no sense from either a humanistic or fiscal point of view to encourage the states to maintain waiver-eligible MR/DD recipients in a perpetually dependent state. And yet, that is exactly the effect of a flat prohibition against payments for prevocational and vocational training under the waiver. There now exists an extensive body of literature which irrefutably demonstrates that even people who are severely retarded and multihandicapped can be trained to be productive employees, if they are offered appropriate social supports and work environment tailored to their particular needs and capabilities.

For that relatively small percentage of recipients who meet the test of waiver eligibility, Title XIX payments should be available to support services aimed at helping such recipients achieve their maximum level of productivity, even though they may never attain complete social and economic independence.

It is important to note that Congress has recognized the need to address the vocational requirements of people who are severely disabled by: (a) authorizing, under the Education of the Handicapped Act Amendments of 1983 (P.L. 98-199), the Department of Education to finance supported employment projects for such persons; and (b) expanding the scope of the Developmental Disabilities Act in 1984 to encompass employment-related services (P.L. 98-527). These policies are Congressional in origin. Yet an inconsistent policy under the HCBC waiver interpretation is advanced by an executive agency. Moreover, that policy is also inconsistent with Congress' own policy, in enacting Section 1915(c), to provide for Medicaid reimbursement for more appropriate and cost-effective services provided in home and community. The CCDD Task Force on Medicaid believes that community care waiver policy should reflect current professional and societal views regarding the most efficacious methods of programming for adults who are severely disabled. Certainly, a strong emphasis on the acquisition and use of work skills must be seen as a central component of any modern policy governing habilitation services for adults who are severely disabled and nonelderly.

C. Process of Reviewing and Approving Waiver Requests

In the preamble to the October 1, 1981 interim final regulations, HCFA outlined its basic philsosphy governing administration of the waiver program, saying its aim was "... to give the states the maximum opportunity for innovation in furnishing noninstitutional services ... with a minimum of Federal regulations." The rules, therefore, attempted to provide general parameters for reviewing state waiver requests, patterned after the provisions of the statute.

This approach, no doubt, contributed to the early success of the program, since states were given broad discretion in tailoring their waiver programs to the unique needs and characteristics of their respective service delivery systems and target populations. However, as HCFA officials gained more experience and began to demand increased documentation, the lack of clear, criteria for judging the acceptability of a state's waiver request emerged as a major problem.

It seems to us that this problem is in no way abated by the publication of final waiver regulations on March 13 of this year, since these rules fail to offer the states operational criteria for determining the boundaries of an acceptable waiver proposal. Instead, they simply spell out the process and procedures HCFA will use in considering a state's request. As illustrated by the earlier discussion of Florida's experience in attempting to get its waiver program renewed, the key elements of a state's proposal--e.g., the number and types of recipients to be covered and the descriptions of services to be provided--end up as a matter of open-ended negotiation between the state and HCFA.

It is worth noting that HHS did not offer the public an opportunity to comment on its revised waiver regulations before issuing them in final form this past March. At the time the original interim final regulations were issued (on OCtober 1, 1981), the states had had no prior experience in developing or operating this type of a waiver program and, therefore, it was not surprising that the Department received only 33 public comments within the 90-day comment period.

Although experience with the program over the succeeding 3 1/2 years has given state officials, providers and consumer advocates a much better grasp of the pitfalls of administering waiver-financed programs, HHS chose not to subject its March 13, 1985 regulations to public review before implementing them. We are convinced that a more workable set of program rules would have resulted had the Department solicited input from the interested public before developing and publishing these rules.

Members of the Committee need to hear about the arbitrary and unpredictable nature of the HCFA review process. Indeed, we can report that this sense of uncertainty which now pervades the program is rapidly eroding support for a highly promising Congressional initiative. Rather than attempting to place blame, however, it is important to pinpoint the source of the problem. In our opinion, the process orientation of current HCFA policies and the resultant lack of operational criteria defining the parameters of a federally approved waiver program consistute a major cause of the current problems related to the review process.

We do not believe that HCFA officials are purposely attempting to obstruct the process. On the contrary, the responsible agency staff appears genuinely committed to making the program work. However, until the federal government's operational criteria for approving waiver requests--not just its processing requirements--are spelled out, we anticipate that the current level of confusion and uncertainty will continue unabated.

V. RECOMMENDATIONS FOR IMMEDIATE COMMITTEE ACTION

The CCDD Task Force on Medicaid respectfully urges the Committee to consider two possible approaches to solving the problems outlined above. One approach would involve amending Section 1915 of the Social Security Act, and the other would entail more farreaching changes in Medicaid policy. A more complete explanation of these two approaches is provided below and complements prior portions of this testimony.

A. Clarifying Amendments to Section 1915

Should the Committee decide that the most practical and politically expedient means of resolving the uncertainties and inconsistencies of current federal policy is to enact corrective legislation, it could amend present law in the following manner:

1. Add to Section 1915(c)(2)(D) of the Act a list of the factors the Secretary is required to take into account in calculating the cost-effectiveness of waiver services. The types of information the Secretary would be obligated to weigh might include (a) statistically valid demographic studies which provide reasonable grounds for concluding that the number of individuals who would require care in a skilled nursing or intermediate care facility is likely to increase if the requested waiver program is not approved or continued; (b) the effect that disapproval would have on past successful efforts by the state to restrict the the number of new admissions and readmissions to SNF, ICF, and/or ICF/MR facilities; and (c) statistical evidence that the relative proportion of recipients receiving SNF, ICF, and/or ICF/MR services under the state's Medicaid plan per 100,000 in the general population is below the national median for all states.

The purpose of this amendment would be to require the Secretary to use criteria that would assure a more equitable comparison of interstate differences that are likely to influence demand for home and community care services among waivereligible populations.

The basic aim is to prevent states such as Florida, Michigan and Nevada, which have comparatively low rates of institutionalization and/or unusually high demand for home and community care services, from being disadvantaged in qualifying otherwise eligible recipients for waiver services.

Unfortunately H.R. 3101 does not respond to this problem.

2. Clarify the definition of habilitation services to permit Medicaid reimbursement for developmentally- oriented services to waiver recipents other than certain educational and vocational rehabilitation services. In our June 25 testimony to the House Subcommittee on Health and the Environment, we recommended that the following new statutory definition be inserted as a new subsection of Section 1915:

> the term "habilitation services" as used in subsection (c) (4) (B) shall mean services designed to assist eligible developmentally disabled recipients to acquire, retain and improve the selfhelp, socialization and adaptive skills necessary to reside successfully in home and community-based settings, including prevocational, educational and supported employment services. Provided that such payments shall not be available to otherwise eligible recipients for--
>
> (1) Special education and related services as defined in Section 602 (16) and (17) of the Education of the Handicapped Act, as amended, which otherwise would be available to such schoolaged recipients through the recipients local educational agency.
>
> (2) Vocational rehabilitation services which otherwise would be available to such recipients through programs funded under Section 110 of the Rehabilitation Act of 1973, as amended.

In major part, the House has incorporated our recommendation into H.R. 3101. (See Section 202, subsection (a)). The House, however, limited "habilitation services" (as newly defined) to people who already have been institutionalized but it excluded people who are at risk for institutionalization. Although this is a major improvement, it does not go far enough. The Senate should adopt the House provisions, but it should also provide that people who are at risk for institutionalization should be included in the final version of the new "habilitation services" definition. This small change would carry out in a thorough and uniform way the policy of Congress in authorizing the HCBC waiver in 1981 as a way to assure appropriate and costeffective services for all people who are eligible recipients.

3. Limit the Secretary's authority to restrict the number of recipients eligible to participate in a Section 1915(c) waiver program, provided the requesting state is able to document the cost effectiveness of the program. This objective could be accomplished by adding a new subsection to Section 1915 of the Act.

   As mentioned earlier, HCFA, in effect, places limits on both aggregate expenditures and the number of clients a state is able to serve under an approved HCBC waiver program. Consequently, a state is not permitted to use the savings that may be achieved by moving recipients from more costly institutional facilities to less costly community programs to provide HCBC services to additional eligible recipients who are at-risk of institutionalization. The necessary statutory language still would require a state to prove that its proposed waiver program would be cost effective (i.e., average per capita expenditures with the waiver would not exceed comparative per capita expenditures without it). Requesting states, however, no longer would be obligated to demonstrate that there would be no increase in the total number of recipients of Medicaid reimbursable long term care services (i.e., with vs. without the waiver). As a result, states would have greater flexibility in choosing the types and extent of services offered to waiver recipients, rather than being forced to serve only the highest cost clients. The House has addressed this problem wisely by providing in H.R. 3101 that the HCFA shall not enforce a policy that requires states to demonstrate an actual reduction of cost as a condition of HCBC waiver approval. The House approach is sound and should be adopted by the Senate. (See H.R. 3101, Section 202, "Modifications of Home and Community-Based Waiver uner Section 1915(c)," Subsection(c), "Prohibiting Imposition of Certain Regulatory Limits.")

4. Prohibit the Secretary from imposing certain regulatory limits

The House (H.R. 3101) wisely has addressed some problems created by HHS-HCFA regulations. The Senate should approve the House version in these respects:

a. HCFA established an operating guideline that HCBC waivered services must be approximately 70-75 percent less expensive than comparable institutional services.

This was contrary to Congressional policy, and H.R. 3101 (Section 202, subsection (c)) makes it clear that *such services shall not exceed 100%* of institutional services cost.

b. HCFA also established a policy of requiring states to *estimate* three years in advance the *cost* of HCBC waivered services and to *absorb* the federal and state portion of any costs that exceed the estimate. H.R. 3101 (Section 202, subsection (c)) prohibits the Secretary from doing this and withholding federal payment on the ground that a state has failed to comply with the estimate.

c. Finally, HCFA established a practice of determining average *per capita expenditures* for physically disabled individuals in inpatient care in ICFs in a way that essentially underfunded those people and thereby excluded them from the HCBC waiver benefit. H.R. 3101 (Section 202, subsection (c)) prohibits such a practice and allows states to compare *comparable costs* in making estimates of HCBC costs.

B. *Authorizing More Basic Reforms in Medicaid Services*

While, as illustrated above, it is desirable at this time to correct some of the more immediate problems associated with the operation of the waiver program through a series of clarifying amendments, the Task Force believes that, in the long run, the only effective means of assuring that community care services are not subject to perverse financial disincentives is to permanently restructure Medicaid policy. In Part II of this testimony, we argued for a reversal of the present assumptions underlying Title XIX. There are two obvious approaches.

One approach would be to authorize home and community care as an optional state plan service under Medicaid. Although the task force recognizes that the Committee must consider the implications of such action for all subpopulations of waiver-eligible recipients, it will illustrate how legislation might be designed for one target population-those with developmental disabilities.

The term "home and community care services for persons with developmental disabilities" should be defined to include: case management services; homemaker/home health aide services; personal care services; adult day health services; habilitation services, respite care; and such other services as a state may request and the Secretary approve. Payments for room and board, however, would be explicitly excluded from the definition. The term "habilitation services," in turn, should be defined to encompass: (a) developmentally-oriented services to Medicaid-eligible MR/DD recipients who have been institutionalied and are at risk for institutionalization, with the exception of educational services otherwise available to such school-age recipients through local educational agencies; and (b) pre-vocational and supported employment services, except for services otherwise available to such recipients through the federal-state vocational rehabilitation program (see definition above).

To qualify for coverage of home and community care services under its state plan, a state should be required to provide the Secretary with satisfactory assurances that, at a minimum, it will: (a) maintain at least its current level of fiscal effort in supporting similar services for eligible (and potentially eligible) MR/DD recipients through available state and local funding sources; (b) restrict such services to MR/DD recipients who, in the absence of such assistance, would require care in Medicaid-certified long term care institutions, the average per capita cost of which was estimated to be equal to or greater than the proposed home and community care alternatives; and (c) institute necessary safeguards to protect the health, welfare and human rights of MR/DD recipients participating in services provided under this plan option.

In addition, the state should be obligated to submit a comprehensive plan which includes: (a) provisions for instituting a comprehensive screening and assessment program to identify the service needs of recipients with developmental disabilities currently placed in SNF, ICF and ICF/MR facilities, as well as otherwise eligible persons with developmental disabilities who are either unserved or underserved and could benefit from home and community care services; (b) provisions for establishing appropriate level of care criteria, together with policies and procedures to be used in determining eligibility for all long term care services offered to Medicaid recipients with developmental disabilities; (c) provisions for establishing a pre-admission screening program aimed at assuring that with persons with developmental disabilities, in need of long term care services, are placed in residential and day program settings that, consistent with their individual service needs, maximize their opportunity for independence and the acquisition of adaptive skills; (d) provisions for systematically reducing the number of recipients with developmental disabilities placed in SNF, ICF and ICF/MR facilities over a multi-year period, (e) provisions for developing, over a multi-year period, the home and community care services required to meet the needs of persons with developmental disabilities currently placed in institutional settings, as well as otherwise eligible persons with developmental disabilities who are unserved or underserved and could benefit from long term care services provided under that state plan; and (f) provisions for coordinating the activities of responsible state and local agencies to achieve the objectives of this plan. Finally, States should be permitted to disregard the provision of the Act related to offering services on a statewide and comparable basis for a period not to exceed five years, provided they have a plan for systematically expanding services to all subgroups of recipients with developmental disabilities in all geographic areas of the state.

A second approach also is available. It is more comprehensive. While recognizing that the inclusion of home and community-based services as a permanent Medicaid state plan option would be a step in the right direction, some of the organizations that support this statement of testimony are firmly convinced that a more fundamental restructuring of Medicaid benefits is required. They believe that the best way to accomplish this objective is through the prompt enactment of the substantive provisions represented by the Community and Family Living Amendments of 1985 (S.873-Chafee and H.R. 2902-Florio).

The Task Force urges the Committee to examine carefully each of the above options as it undertakes the complex task of reforming Medicaid long term policy.

VI. HCFA "LOOK BEHIND" AUDITS JEOPARDIZE GROUP HOMES: LIFE SAFETY CODE LEGISLATION NECESSARY

As a result of the new federal "Look Behind" audits spurred by Senator Lowell Weicker's recent hearings on institutional care, certain facilities are facing decertification due to their inability to meet ICF/MR standards. Although the CCDD applauds the efforts of the Federal Government to enforce the ICF/MR rules, it has some serious concerns. Of specific concern are the interpretive guidelines being used by Federal officials to ascertain complicance for fire safety in small (less than 16 beds) ICF/MR facilities that utilize the lodging or rooming house section of the Life Safety Code. Although the CCDD supports the need for appropriate fire safety standards in the ICF/MR program, the application of the guidelines for emergency evacuation is believed to be unreasonable and has led to the erroneous decision by HCFA to decertify group homes.

The guidelines released by HCFA in November, 1984 but not readily available to many facilities until March, 1985 allow only "verbal and/or visual prompts" by staff to residents during fire drills to ascertain the ability of residents' capacity for "following directions and taking appropriate action for self preservation under emergency conditions."

Two group homes in Washington State (Seattle and Bremerton) were given only days to correct the deficiency, train the residents, move them out of the group home, or utilize a stricter fire safety code (e.g., fire sprinklers, etc.) or their Federal funds for the entire facility would be lost. Within a week of this notification the facility would lose its Federal funds. Similar problems are reported throughout the country, in increasing numbers.

It is inconsistent and unwise policy that community-based group homes are given only days to remedy problems while large institutions, usually with multiple deficiencies, are given months and years to make corrections. That is the inconsistency. Such short notice may lead to the reinstitutionalization of severely retarded residents, hardly a desirable outcome of these audits. That is the unwise policy. The Task Force on Medicaid of the CCDD wrote to HHS Secretary Heckler on July 16, 1985, requesting immediate modification of federal rules and guidelines governing life safety for persons receiving services in small community homes certified under the Title XIX as ICF/MR facities. The substantive content of that letter is set out below:

It is our understanding that a notice of proposed rule making has been drafted by HCFA which would adopt the 1985 edition of the National Fire Protection Association's Life Safety Code for Medicaid certified facilities. The 1985 Code includes a new Chapter for board and care occupancies. This chapter incorporates a Fire Safety Evaluation System for Board and Care Homes (FSES/BC) which gives consideration not only to the structure in which people are living, but to the abilities of those living in the home and to staff which will be able to assist residents in case of an emergency. Tne utilization of alternative combinations and levels of protection will provide fare greater flexibility to agencies which operate small ICFs/MR, and it will permit persons with more severe disabilities to live in more normalized environments.

The HCFA action transmittal number 169, which provides Medicaid surveyors with a method of testing the self-preservation capabilities of residents of small homes certified under the lodging and rooming house chapter of the 1981 Code, is creating problems which we believe will be largely alleviated by the adoption of the 1985 edition of the Code.

The undersigned organizations are strongly supportive of the strict application of life safety standards, but there are factors surrounding the current situation which demand a common-sense approach to enforcement of HCFA rules and guidelines. The new chapter for board and care homes, with the accompanying FSES/ BC, was developed with funding from the Department of Health and Human Services specifically to meet the life safety needs of persons with developmental disabilities. HHS has had the report since January of 1983, but deferred action until the work could be included in the NFPA Life Safety Code. The Code has been available to the public since April of this year, but for unknown reasons, HCFA has not yet published the NPRM. In the meantime, Medicaid beneficiaries who live in homes that would likely meet board and care provisions are being transfered to ICFs/MR that meet far more stringet health care requirements, or small ICFs/MR are being decertified because one or two residents of the home did not meet requirements of the strict test for self-preservation, and the provider refused to disrupt the client's life by transferring him or her to an institution when it was believed the individual's life was not in jeopardy. These situations have included:

1) People who do not meet the current HCFA definition of ambulatory because they use a cane, crutches and/or a brace to walk, but who demonstrate the ability to leave a building as rapidly as someone who does not require such devices;
2) People who require physical prompts from staff, such as outlining a cross on the back of a person who is both deaf and blind;
3) Persons who are not capable of self-preservation but who have one-on-one awake staff available 24 hours a day.

The CCDD Task Force on Medicaid strongly urges that the NPRM be put on a fast track and published for public comment immediately. In the interim, we ask that the test for self-preservation be modified to permit physical as well as verbal prompts, and that the status of small ICFs/MR that apply the lodging and rooming house chapter of the 1981 Code be extended when, in the opinion of local fire marshals, the home meets 1985 board and care requirements and clients are not in jeopardy. Transfers that are being made due to HCFA's failure to take more immediate action to adopt the 1985 edition of the Life Safety Code are unnecessarily disruptive to the lives of people who are developmentally disabled. It is in their best interests that we make these requests.

HHS responded on August 6, 1985 through Sharon Harris, Acting Director, Office of Survey and Certification, Health Stands and Quality Bureau. Ms. Harris reported that the CCDD letter has been referred to HCFA, did not indicate that the proposed rule change would be put on a fast-track review, rejected the CCDD request that physical prompts be allowed, and rejected the CCDD request for an extension of certification for small ICFs/MR that, in the opinion of local fire marshalls, meet 1985 board and care requirements. The proposed rule change also does not appear on HCFA's most recent agenda of proposed regulatory changes. By acting now, Congress can correct a situation that jeopardizes the covered small ICFs/MR and their residents, some of whom undoubtedly will have to be re-institutionalized or institutionalized for the first time or relocated into code-complying ICFs/MR.

The time has come for Congress to provide, as an amendment to the Medicaid Act, that HCFA shall apply the 1985 Life Safety Code in determining the Fire Safety of ICFs/MR, including allowing Chapter 21 of the 1985 Life Safety Code to be used in determining the fire safety of small ICFs/MR.

VII. CONCLUSION

The Task Force appreciates this opportunity to bring its views to the Committee's attention and stands ready to be of assistance in formulating an appropriate legislative response to the current problems surrounding the operation of the Medicaid home and community care waiver program and to the Medicaid program as a whole.

Respectfully submitted,
CONSORTIUM FOR CITIZENS WITH
DEVELOPMENTAL DISABILITIES
By H Rutherford Turnbull
H. Rutherford Turnbull, III
President, American Association
on Mental Deficiency

The CHAIRMAN. Mr. Turnbull, let me ask you a quick question. Senator Bradley is right; he and I and most of the members of this committee have been up to our necks in home health care for half a dozen years, getting the waivers from HCFA last year for proven, effective home health care programs, where there was a limit on the total amount of money that could be spent anyway; it was just a question of serving more people at home than less people in institutions. It is all true.

I know what this administration is afraid of, and I know what the Carter administration was afraid of, and that is utilization by people that get no coverage now. And everyone was burned by Medicare and Medicaid. We had no concept as to what this was going to cost us when we started into it 20 years ago.

How do we make sure, as we move toward home health care, which is better, cheaper care than institutionalized care, that we don't suddenly have millions and millions of people asking for home health care that never, otherwise, would have been institutionalized?

Mr. TURNBULL. The "woodwork" problem is a difficult one, Senator Packwood. My suggestion to you is that the way to contain it is to maintain the definition of the eligible recipients, so that we still talk about people who are severely disabled and income-eligible.

If the cost in fact is less expensive in the community, and we believe that for most people it is, then it seems to me that not changing the definition, or changing it only somewhat, is the way to keep the cost lid on.

The CHAIRMAN. Well, when I say we have "been burned," I don't mean wrongly, just in error, I guess, by entitlement programs, having no cap on them and having no idea how many entitlees there were going to be.

Senator Durenberger.

Senator DURENBERGER. Dr. Gilmour, has AARP done an analysis of the second surgical opinion programs where they exist, and determined that that is a preferable way to limit unnecessary utilization as compared to other programs? None of us disagree with John Wenberg in all of his studies, but have you done an analysis across the country of way second surgical opinions are working and come to the conclusion you came to on that?

Dr. GILMOUR. I am not sure that AARP has itself done an analysis.

Martin, do we have one?

Mr. CORRY. Senator, we have looked at the number of the options pursued. We certainly have looked at what the experience has been with private insurers. Needless to say, you are dealing here with a constituency that I think you have expressed some concern about. We have certainly borne that in mind.

I think our concern is that a second opinion program be a universal program, in that all individuals who have a diagnosis of surgery in the categories for which the legislation might require it be subject to second opinions.

Obviously, the legislation provides for a waiver in the event of hardship; but we have tried to look around at what the potential is and still view the desirability of second opinion to far outweigh some of the potential problems which I think you have tried to address.

Dr. GILMOUR. We have not made an actual analysis, have we?

Mr. CORRY. Not a full-scale one. We have looked at some in the private sector.

Senator DURENBERGER. I don't think anybody can deny the fact that, with all of the incentives to cut, that you could find these problems. But with the changes in both the prospective payment system, the increase in prepaid health plans, and so forth, all the incentives are starting to change.

And I was curious to know, before that we mandate that every person must go through this process, which is not a convenient process for anybody, have we looked at other alternatives?

For example—and John and I have been talking about this—now that the peer review organizations have some experience with preadmission screening, how do we involve them in that process? And one of his concerns, and a very legitimate concern, is that, while we are doing such a poor job of paying peer review as it is, and we have got OMB sitting down there trying to cut the legs out from under adequate peer review of the process, if you gave it to the peer review organization without giving them the resources needed to utilize second opinion surgery where necessary, then we wouldn't be achieving our objectives, there either.

But is there some way that you would like to see second surgical opinion used selectively by people who are already in the business of preadmission screeing? And wouldn't that be helpful, to integrate those two?

Dr. GILMOUR. Well, I can say that many of the PRO's that I have known are not really at the present time in a position to give that second opinion.

As a practicing physician through many years, I am happy to be an advocate for the surgeons, which I am not, and the decision to do an operation is not an arbitrary, casual decision by any surgeon. It is a combination of his criteria, his training, his background, and so forth, and it makes a tremendous difference.

Now, if there is going to be a second opinion available, that is not necessarily going to make him suddenly change his ideas as to whether the operation should be done or not. He is going to give, I would say, a reasonable, honest opinion of wnat he thinks, and he is going to be perfectly willing to have someone else reverse that.

The operation on an older person, particularly, is a very, very severe hardship itself, and a hazard. The exclusion of hardships for the second opinion in certain instances is already made available. And I think any thing you can do to enable a person to have a second opinion and not to have to question their doctor, which a person who has been going to a doctor a long time—some of my patients did question me, but [laughter].

Senator DURENBERGER. Would you restate for me, Dr. Gilmour, the premise on which AARP objects to an increase in the part B deductible? You are asking, perennially, for increased benefits and increased coverage in part B. Tell me why it is that $75 today is the limit. Seventy-five dollars was the limit a long time ago; it is still the limit. Most other plans are $100 or $200, or something else.

But AARP, on behalf of me, now that I am a member, and everybody else says $75 is all we can afford. What is the rationale?

Dr. GILMOUR. Our objection to the increase in that?

Senator DURENBERGER. Yes, to increasing the deductible.

Dr. GILMOUR. Well, increasing the deductible doesn't help the poor people at all.

Senator DURENBERGER. How many poor people are Medicare beneficiares, by your definition?

Dr. GILMOUR. I would say 25 to 35 percent of those who are Medicare eligible.

Mr. CORRY. That would be, roughly, not only those in poverty but the near-poor as well.

Senator DURENBERGER. These are people who cannot afford an extra $25 for the access to the Medicare system. Is that what you are talking about?

Dr. GILMOUR. Well, I won't say they can't afford it; but it would be a hardship added to the other costs because, you see, Medicare only pays less than half of their total medical bill right now.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

I want to thank Senator Durenberger for asking about mandatory second opinions. It saves me from asking.

Senator DURENBERGER. Well, we are both trying to find the answer.

Senator HEINZ. Yes, and I think we will. I think we will find a good answer.

Dr. Gilmour, one issue we really haven't talked about here—and I thank you and welcome your testimony in support of a mandatory second opinion—is on the issue of coverage continuation for people that lose it in one way or another.

As background, I am today in the process of introducing a bill which will provide for the continuation of coverage for widows and divorced spouses of employees. In other words, there will by a buy-in, a mandatory buy-in option available for widows or divorced spouses to the health insurance that they had prior to their change in status, and that will be a 2-year option for them.

Do you support that provision?

Dr. GILMOUR. We do, indeed. Two years or more. We think that less than 2 years doesn't give a person who has either been widowed or divorced an opportunity to arrange their affairs, to get things in order and decide what they want to do. They need at least that much, maybe more; but at least 2 years.

Senator HEINZ. There is a House provision—I guess it is H.R. 21, or something like that—that does provide for more years: 4 or 5, as I recollect.

We have tried to work with both your organization, with OWL, the League of Older Women, as well as the Washington Business Group on Health and the National Association of Manufacturers. And we believe that our legislation is going to be supported broadly by that group and will solve a very serious problem that currently affects some 5 million people just in those 2 categories; if you count the widows and the divorced spouse and the dependents of them, we are talking about 5 million people who would have access to health insurance that now literally don't have that option.

Do those statistics pretty much square with your understanding?

Dr. **Gilmour**. The number 5 million? I am not familiar with that, myself.

Mr. **Corry**. Yes, sir.

Senator **Heinz**. Mr. Corry, do you believe that is approximately correct?

Mr. **Corry**. In particular it is a great problem for widows, women who are divorced, particularly with dependent children. And we support your efforts and the efforts in the House to try to resolve this gap in coverage.

Senator **Heniz**. Well, it is my hope that we can make this a part of reconciliation. It is an urgent matter. It has no cost to the Federal Government.

I apologize to the chairman for not having given him more information on it yet; but we were only able to introduce the legislation today, and I hope that the members of the committee and the staff will take a careful look at it. I think it is responsible and good legislation.

I have no further questions, and I thank you.

The Chairman. Senator Bradley.

Senator **Bradely**. Thank you very much, Mr. Chairman

I thank each of the witnesses for their testimony. Just confirm with a yes or no, do you suoport the State option system over the State waiver system.

Dr. **Gilmour**. Yes. In other words, we feel that in North Carolina we also had a rather difficult time getting our waiver, and it still is not as effective as we would like it to be in its implementation and its compensation.

I think if the State had the option of doing it, the home care is the greatest challenge and the greatest opportunity we have. If we can keep people out of institutions—and what we are concerned about is cutting down the costs—then we will have the greatest opportunity for the future, and particularly so at the present time when our older population, and particularly those over 85, is increasing so fast. There is going to be a great necessity

There is one thing about home care that the waiver will enable us to do, and that is the humane part of the home care. It is not just an economic situation. For a person to be able to remain in their home, in their normal environment, for longer than they could otherwise, is a tremendously important thing for their life. And so we favor the State being able to do it without redtape.

Senator **Bradley**. And we really are talking about a very small number of people here that the State chooses to provide home care to.

One aspect of the bill that both of you have expressed support for is that the cost should be neutral; in other words, that we really would test our premise, which is that providing home care for citizens in their homes is in the long run cheaper than providing care in institutions. And if a State chose to go with the State option, it must demonstrate that it would not increase the overall cost.

We think that that is a prudent way to go, and I think that that is also, as you say, Dr. Gilmour, a "humane way to go."

Being realistic, I am not so sure the committee is ready this year to go with a State option program. Therefore, there are a number of other steps along the way toward a State option that have been proposed, and I would be curious to hear your reaction to them.

In your testimony you did support the changes that were made in the House reconciliation bill; is that not true? The so-called Waxman changes?

Dr. **Gilmour**. They were options. I think our position is now—and I will see if Martin concurs in that—that we feel, still, that it is not as good as the original proposal.

Senator **Bradley**. It is not as good, but there are steps along the way.

Dr. **Gilmour**. It is better than nothing.

Senator **Bradley**. Another suggestion, and I happen to think it is a very good suggestion, actually made by the chairman, is to provide case management services as a State option. You do support that, don't you?

Dr. **Gilmour**. Well, I support it with one reservation: The phrase "case management" means you have got to have something to manage. And if you have a case manager, and right now we are working hard to get a case management installed in North Carolina on a different level, you have to have the services for them to manage. And if you have an adequate case management system and not good home services—and I do like to distinguish between home health and home care to some degree because some of the home care services will enable the people to be independent at home, life chore services and so forth. And so case management needs to have something to manage. If there are not sufficient services available, then it is not a good option.

Senator **Bradley**. As steps along the way, would you also support something Senator Chafee and I have been looking at, and that is extending the waivers from 3 years to 5 years?

Dr. **Gilmour**. Yes. Anything to keep from interfering with it.

Senator **Bradley**. Would you support another possibility, which is a moratorium, say a moratorium for the next 2 years, on terminating any waivers?

Dr. **Gilmour**. Yes.

Senator **Bradley**. OK.

Mr. **Corry**. Senator? If I could offer a further comment. In the past we have supported the moratorium. With the final regulations in place, we feel that the moratorium should not be used as an extended device. It might be the last resort, which the committee might have to reach for in order to get a resolution of this problem. But we think it is better to try to correct the problem.

Senator **Bradley**. If I could ask for Senator Chafee, I would like to simply ask Mr. Turnbull a question. This is for Senator Chafee, who couldn't be here. He would ask this question of Mr. Turnbull.

It is:

> Professor, as you well know, it is now 10 years since the Education for the Handicapped Act was passed. It dramatically improved special education services in the country. Now that the first generation of special class graduates are leaving schools where they were mainstreamed, how will this change our assumptions about the types of residential services we need?

Mr. **Turnbull**. It changes it dramatically, Senator Bradley. My son is one of those first-generation students under Public Law 94-142.

Our assumption all along has been that he and children like him would be educated in the community, would live in the community, would work in the community, would be community members in every way.

When the absence of community care is as great as it is, then the assumptions that we have made cannot be carried out. It is absolutely important, then, for us to continue the direction of the Education of the Handicapped Act, Public Law 94-142 in particular, by moving forward with the creation of more options for community care, and to take the Federal funding streams and to redirect those funding streams into the community rather than into the institutional care, if the promise of 94-142 and the EHA is going to be satisfied, and if the expectations and the assumptions that we have grown up with are to be satisfied also by the Congress.

Senator **Bradley**. Thank you.

The **Chairman**. Senator Heinz.

Senator **Heinz**. Mr. Chairman, thank you.

A couple of brief questions. Earlier I mentioned to Dr. Gilmour the Katie Beckett case, and there are an estimated 2.200 ventilator-dependent Medicare and Medicaid patients confined to hospitals today because of our present arcane and inflexible Federal health care benefit rules. Of those 2,200—and maybe you don't have this—what proportion of them or what number of them do you think might be senior citizens or Medicare beneficiaries?

Dr. **Gilmour**. 2,200 patients confined to the hospital? I'm sorry.

Senator **Heinz**. Yes; the ventilator-dependent confined to hospitals.

Dr. **Gilmour**. I have no idea how many of them. Of course, the relative proportion of older people would make you think there might be some of them, but I don't know.

Senator **Heinz**. My suspicion would be that the majority of them would probably be seniors.

Dr. **Gilmour**. That is what I would think.

Senator **Heinz**. Does anybody have any idea?

Mr. **Corry**. I cannot answer that.

Senator **Heinz**. That is just informational. I thank you.

Second, we were talking earlier about the necessity of the continuation of the Hospice Program. I think we all know that cancer is the second most frequent cause of death among Americans over age 65. How important is it to older Americans to have a Hospice Program available to them in cases like that?

Dr. **Gilmour**. Well, this is my opinion, and I suspect it is AARP's opinion, too: I think the Hospice Program has been one of the greatest and most humanitarian steps that the medical care in our society has made in the last decade.

I have watched patients through many years with this illness, and what Hospice can do for them—and we forget sometimes—for their families—during the last illness—is immeasurable. My own daughter-in-law is a nurse, and she has just started a Hospice Program in New Hampshire, about which I am delighted.

Senator **Heinz**. The administration wants to sunset the Hospice Program again after 2 years. A number of us want to repeal any sunset and treat hospice like any other Medicare benefit. Which position do you favor? Or do you favor some second position?

Dr. GILMOUR. The AARP feels Hospice should go on indefinitely, and I would like to more than underscore that personally. And if you are going to talk about economics, the cost of preserving a life during the latter part of the life, about half of the money we spend is spent in the last year of a person's life, anyway. And with cancer the cost can be immeasurable—I can give personal experiences—whereas in a home the cost is far less, with adequate hospice coverage, and the person is much more happy, and the family is much more satisfied.

Senator HEINZ. I have been advised that the reimbursement for hospice care is about $20 a day lower, on the average, than the actual cost of delivering the service, and even as much as $50 a day underrimbursed in some parts of the country—like Missouri.

From your understanding of reimbursement—and maybe you don't have detailed knowledge of it—are those statistics accurate?

Dr. GILMOUR. Well, I don't know enough to say whether they are accurate or not. I think it would probably differ with certain hospice programs, because, as you know, volunteers give a tremendous amount of time to the hospice programs. So, to figure the actual cost one place as against another might be difficult. But I would doubt seriously if the reimbursement is sufficient to pay the basic costs.

Senator HEINZ. My last question has to do with home health care, something that Senator Bradley and many of us are interested in, in a little different context than the waivers, and this is this:

As you know, the administration has been cutting health care. We have had an argument on the issue of intermittent care with them. Does AARP have any data to show that, as a result of DRG's, as a result of the prospective-payment mechanism, that seniors are being discharged from hospitals sicker and quicker, and that therefore the need for such follow-on care as home health care or skilled nursing care or intermediate care, but particularly home health care, is therefore necessarily greater than before?

Dr. GILMOUR. Well, that data is available. I am not sure whether it is AARP's data or not. But the people are being discharged quicker and sicker. In my hometown I am chairman of a committee called PACE, which is Providing Affordable Care for the Elderly. We find the older people are out of the hospital before their families can take care of them, before the nursing home, even a skilled nursing home, is quite equipned to take care of them. It is creating quite a problem, which is one of the reasons their medical costs are going up. They are going out of the hospitals into skilled nursing care quicker than they would have otherwise.

Do we have any data on that beyond the general data that I know?

Senator HEINZ. Mr. Corry.

Mr. CORRY. Senator, as you know, GAO recently completed a study in that area. In addition, there is a good bit of anecdotal information indicating that people are being discharged earlier. It underscores the need for the types of things which home health can provide, and the necessity, again, of correcting the problems of the 21-76 waiver.

Senator HEINZ. That is certainly a very important part of it. I thank you.

Thank you, Mr. Chairman.

The **Chairman**. Other questions?

[No response.]

The **Chairman**. Gentlemen, thank you very much.

Mr. **Turnbull**. Mr. Chairman, I would like to file for the record a response to Senator Bradley's several questions to Dr. Gilmour, if I may.

The **Chairman**. Absolutely.

Mr. **Turnbull**. Thank you, sir.

Dr. **Gilmour**. Thank you very much.

The **Chairman**. Thank you, sir.

Now, if we could have Jack Owen, Mike Bromberg, Paul Willging, Robert Armitage, and Dr. Douglas Williamson.

Mr. Owen, go right ahead.

STATEMENT OF JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, DC

Mr. **Owen**. Thank you, Mr. Chairman. I appreciate very much the opportunity to testify on the range of issues affecting hospitals now being considered by the Finance Committee.

The **Chairman**. Let me interrupt you once again to say what I have said to other witnesses: Your statement will be in the record in full, and we would appreciate it if you would abbreviate your oral presentation.

Mr. **Owen**. Fine; I want to emphasize that the biggest problem that we are running into in the hospital field is the concern about equity in applying any deficit reduction measures to the Nation's hospitals. We understand the difficulty that this committee has in dealing with equity because of the budget deficit and the lack of money that is available, and we also want you to understand that it is difficult to measure equity as far as the hospitals are concerned because so many of them came in at different points in this PPS Program. We have some hospitals that are now completing 2 years. Many of our teaching hospitals have just completed 1 year; and we still have some hospitals, with fiscal years beginning on September 30, that have still not completed 1 year. So, it is difficult sometimes to determine what is equitable.

The most important thing that we would like to bring to the committee is that modifications to PPS should be made by Congress. We think that the regulations that have been promulgated by HHS do not reflected the intent of Congress and we feel that this committee, along with its counterparts in the House, should act quickly so that the regulations that have been issued do not become effective, but the actions of Congress itself should be what we adopt.

We feel also that during the next year certain equity issues need to be addressed. We have to improve the PPS Program now because every year we are going to be back here arguing about the rural-urban problem, the indirect education problem, and the wage index; and it appears to us that this coming year ought to be the time to take action on these issues.

We went into this program, Senator, with the idea that hospitals were going to receive an increase based on the hospital market basket plus a percentage for technology. It appears—certainly from the regulations that have come out—that the administration seeks a freeze, and from what we hear in the House, it is likely to be only a 1-percent increase.

If we do not have a market basket plus a quarter of 1 percent, then I would strongly urge that there be a hold-harmless clause in whatever bill comes out so that no hospital receives less in fiscal year 1986 than it received in fiscal 1985.

We feel that if the Department changes the wage index and recalibrates, and that even if this committee comes up with only a 1-percent increase, we will have a problem in trying to meet the needs of the health care of the elderly.

I recognize that this creates a problem in the transition--one in which the field is definitely split between those hospitals that want to move forward toward the national rate and those that don't—but without a market basket increase plus a percentage for technological changes, some hospitals in every State will get less. And I am sorry that Senator Heinz isn't here because I think, as hospitals get less, we are going to see more patients being discharged quicker, which is the whole object of the program. And when they are, then we are going to need more money for home health care and for other agencies to take care of these patients.

I would again applaud what you have done on the issue of hospitals serving a disproportionate share of low-income patients. I think it is time for us to move on this adjustment. It has been on the books now for 2 years, and I think your bill addresses that very well, as does the House package. ProPAC has looked at this problem. CBO has looked at it. HCFA has looked at it. We have looked at it. And we do think the figures are there to show that there is a difference between those hospitals that take care of a large number of Medicaid or poor, and that the Medicare patient does deserve an additional amount of money.

We are delighted to see that you did not leave out the rural hospitals because we think both rural and urban hospitals should be included.

As far as Senator Durenberger's outpatient surgery bill, we believe that outpatients should eventually be part of the PPS system. We do have some concern as to how that rate will be set because in the ambulatory care setting rates are determined differently than they are in hospitals. We think there should be a strong look to see whether the severity of illnesses requires different treatment of hospital outpatient departments and ambulatory surgery centers, but we are not opposed to the principle.

We are opposed, however, to Senate bill 1550, which was introduced by Senator Durenberger, at the request of the administration, we understand. But this bill has three sections which would nullify a long series of Federal court victories achieved by hospitals across the country in overturning some HHS policies.

It would be unfair to change the rules after hospitals have so faithfully adhered to them, and PPS is now going to change these issues of malpractice and labor room in the future, anyway. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Michael Bromberg. Mike.

[The prepared written statement of Mr. Owen follows:]

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Jack W. Owen, executive vice president of the American Hospital Association. The AHA represents over 6,100 member hospitals and health care institutions that annually provide services to more than 10 million Medicare beneficiaries. The Association also has approximately 38,000 personal members. I am pleased to have this opportunity to address the complex issue of deficit reduction and to continue the dialogue on Medicare prospective pricing.

Prospective pricing represents a dramatic, and constructive, change in Medicare payment policies. The strong, positive responses of hospitals to the incentives created by the new system demonstrate that economic incentives are more effective than regulatory controls in containing health care costs. Although all acute-care hospitals that participate in Medicare--except those in the waivered states--now are paid under prospective pricing, the task of implementing the system is far from complete. As hospitals have entered the system, they have confirmed the existence of problems--some anticipated and some unsuspected when the plan was designed.

In developing the system, Congress wisely included a three-year transition period, during which problems could be identified and resolved before they resulted in serious damage to the nation's hospitals. This hearing, and the issues that are raised today, can be an important step toward the goal of achieving an equitable prospective pricing system while meeting the reconciliation instructions of S.Con.Res.32, the First Concurrent Budget Resolution of 1985.

JURISDICTIONAL AND DATA CONCERNS

Prior to commenting on specific proposals before this Committee, I would like to take the opportunity to address Association concerns regarding congressional jurisdiction over prospective pricing issues and availability of data on the impact of the system on hospitals.

The first concern is the intent of the Department of Health and Human Services (HHS), first expressed in FY 1986 budget documents, and evidenced most recently in the final FY 1986 Medicare Prospective Pricing regulations published on September 3, to freeze hospital DRG rates and certain other payments--such as those for services exempt from the prospective pricing system and those for direct medical education--by regulatory action. The Association believes that any such fundamental changes in the operation of the PPS should result from legislative, rather than regulatory, action, and sees this Committee, as well as its counterparts in the House, as a forum for discussion of such initiatives.

The second concern is the difficulty of assessing the impact of PPS on hospitals. Many hospitals have just recently completed a full cost-reporting year under the system, and they have not yet filed Medicare cost reports. Consequently, it is impossible to assess the extent to which Medicare prospective pricing has affected their overall financial performance. Moreover, hospitals' experience during their first federal fiscal year under prospective pricing is of limited value in anticipating the impact on them once the system is fully implemented.

However, the AHA has carefully examined the data that are currently available, that is, the data used to establish prospective prices during the first and second years. Although these data admittedly are not as current as would be desirable, they do indicate the general pattern of impact on hospitals.

The Association is eager to update its analysis, using more current information once the data are made available by HHS' Health Care Financing Administration (HCFA). The use of timely data would be particularly valuable because the decisions made during the next month will shape prospective pricing's third year. It seems, however, that more current data will yield results that generally are consistent with results obtained from use of the older data. HCFA must begin to release data upon which it relies for policy decisions sufficiently early to provide the hospital community an opportunity to evaluate conclusions drawn from that information.

EFFECTS OF THE TRANSITION TOWARD UNIFORM RATES

In determining the FY 1986 payment policy for hospital services under PPS, the Committee must consider the impact of the current schedule for transition to national payment rates. If the FY 1986 rates are set at or close to the FY 1985 levels and the transition is allowed to move to its next phase on October 1, then fiscal restraint will be unevenly, and unfairly, applied on a hospital-by-hospital basis. This is due to the fact that, under the transition, the three standardized amounts used to calculate per-case payments in each hospital are changed in their proportion of overall payment. Since these three base rates are different amounts, changing their proportionate weight changes final payment.

Therefore, if the transition is permitted to continue while Congress limits hospital rate increases, then there will be hospitals in every state which will receive less per Medicare case then they are receiving in the current fiscal year.

Understanding the interplay between the rates and the transition is crucial for the Committee in setting the FY 1986 policy.

The AHA recommends that the Committee temporarily delay the transition schedule while the limits on rate increases are in effect, so that no hospital receives less per Medicare case next year. To do otherwise would exacerbate the problems caused by suspending the annual rate adjustment policy. Fiscal restraint in the Medicare program should be applied fairly among hospitals, and holding the transition at its current phase is essential in achieving that equity.

GRADUATE MEDICAL EDUCATION

Just as the Association opposes the Administration's unilateral freezing of Medicare PPS rates, it also believes that HHS in publishing its regulations to freeze the direct medical education pass-through has preempted Congress' authority and responsibility .

It is clear that changes are inevitable in the financing system for graduate medical education. Indeed, they already are occurring. Due to the close connection between medical education and medical care, such changes--considered cautiously and implemented incrementally by Congress--should take into account the effects of reforms on the number and distribution of physicians, medical education programs, and the provision of patient care.

The AHA urges the Committee to keep in mind this fundamental unity of medical education and medical practice in determining the share of graduate medical education costs that Medicare will pay.

AREA WAGE INDEX

Imperfections in the system of diagnosis-related groups (DRGs) and the setting of prices are not the only sources of inequities. The original design for the PPS calls for an adjustment to the prices to reflect the level of wages prevailing in the labor market of each hospital. This adjustment is made using a wage index that is intended to reflect the difference between the average wage of hospital employees located in each area and the average wage of hospital employees nationally. For this adjustment to achieve the goal of the legislation, two elements are necessary:

- The areas for which indexes are computed must coincide with the actual boundaries of hospital labor markets; and

- The index values must reflect differences in average hourly compensation of hospitals employees in each area.

For several years, industry groups have been concerned with the limitations of the HCFA index. During the first prospective pricing year, HCFA acknowledged the limitations of the current wage index and convened an advisory group to examine alternatives. Eventually, HCFA determined that it would be necessary to collect new data that would make possible the identification of the actual hourly wage prevailing in each area. A survey of all hospitals was conducted, to which over 90 percent responded. More significantly, the data submitted by hospitals were reviewed by fiscal intermediaries and reverified by the facilities themselves. A sample of the data was audited by the HHS Inspector General and found to be accurate. In short, these data have been subjected to greater scrutiny than those previously used to compute the wage index.

In the final rule for FY 1986 Medicare PPS rates, published September 3, 1985, the new data have been incorporated into a revised area wage index. It is interesting to note, moreover, that the Secretary has delayed the implementation of retroactivity until April 1, 1986, to allow Congress time to act on this aspect of PPS. When the provision requiring retroactive application of any new formulation of the area wage index was first enacted, it was envisioned that the new index would be available in a few months. In fact, the data were delayed for well over a year. Retroactive application of certain equitable adjustments in a prospective system may be appropriate in the short term, but over a long period it disrupts the payment system. Hospitals are in general agreement that the new wage index should be applied prospectively. Even HHS, in its June 10, 1985 Notice of Proposed Rulemaking, indicated that retroactive application of the survey-based wage index would be inappropriate.

It should be noted that HCFA has yet to address the adequacy of Metropolitan Statistical Areas (MSAs) as definitions of hospital labor markets. Several rural hospitals located near urban areas have reported significant difficulties arising from wage adjustments that are substantially lower than those received by neighboring urban hospitals. Therefore, the AHA has urged HCFA to undertake the research necessary to create more equitable labor market definitions, and is planning to use the new wage data to explore several alternatives. It is important that this issue be addressed.

The controversy surrounding the area wage adjustment demonstrates the critical need for accurate and reliable data in a pricing system based on uniform average rates.

DISPROPORTIONATE SHARE ADJUSTMENT

The AHA, concerned by HHS' failure to implement--as directed by Congress--a Medicare adjustment for hospitals that serve disproportionately large numbers of low-income or Medicare patients, urges this Committee to provide for such an adjustment in its FY 1986 deficit reduction bill. The Association believes that implementation of a disproportionate-share adjustment is both essential to hospitals' sense of fair treatment under the Medicare PPS and critical to the availability, accessibility, and quality of needed health services.

Under prospective pricing, Medicare payments to hospitals differ across the nation, with variance according to a hospital's patient mix, area wage level, and location, as well as by the system's phase-in schedule toward national prices and its price adjustments to recognize hospitals' specialized roles and circumstances. In terms of the latter, under law, special treatment is permitted rural referral centers, cancer treatment centers, sole community providers, hospitals in MSAs that span regions, facilities redesignated as urban rather than rural, and, as stated, hospitals that serve disproportionately large numbers of low-income or Medicare patients.

Although HHS has recognized and implemented the other adjustments, it has failed to exercise authority regarding provision of a disproportionate-share adjustment, despite the fact that the Secretary was directed to implement such an adjustment by both the Social Security Amendments of 1983 and the Deficit Reduction Act of 1984. As hospitals enter the third year of the PPS, the Secretary, under court order, has issued only a vaguely specified appeals procedure--since stayed--for self-defined disproportionate-share providers.

HHS has failed to act despite extensive documentation of the need for an adjustment by the Prospective Payment Assessment Commission (ProPAC) and other organizations. ProPAC, after reviewing studies by the Congressional Budget Office (CBO), HCFA, and the AHA, concluded--in an April 1, 1985, report to the Secretary--that it "is convinced that hospitals serving a high volume of low-income patients (as measured by a variety of definitions) do incur higher Medicare costs per case. ...The precise reasons for these higher costs are unknown. Based on its studies, however, the Commission is also convinced that these higher costs per case are substantially due to factors beyond the control of these hospitals."

In the AHA's view, HHS' delay in implementing the adjustment, supposedly in order to gain more data on the issue, is totally unwarranted. The issue at this point is not whether or when to implement an adjustment, but how to do it. Based on the weight of economic evidence, the ProPAC recommendation, and the risks of further HHS delay, the AHA recommends that this Committee:

- Mandate an adjustment for FY 1986;

- Avoid low-income measures that are essentially Medicaid-only because such measures fail to capture the full extent of medical resources committed to low-income patient care (for example, they omit large categories of low-income patients, such as childless couples and the uninsured working poor, and are unfair to hospitals that are heavily committed to serving those populations);

- Adopt a "Medicaid plus uncompensated care" measure as the most practical, sensitive approach for the time being, with verification of data by Medicare fiscal intermediaries;

- Apply the adjustment to rural as well as urban hospitals, with recognition of the potential hardships for rural hospitals of a Medicaid-based, low-income service measure, and consideration of the need to refine labor-market boundaries for both rural and urban areas and of the problems of hospitals with naturally unstable admissions and case mixes, although the payment system assumes these "average out" over each hospital's fiscal year; and

- Provide for an explicit period of continued study of unresolved prospective pricing issues.

The AHA is committed to enactment of a disproportionate-share provision this Congressional session. To reflect this commitment, the Association has asked 1,248 hospitals--that, according to AHA 1983 Annual Survey data are above average in percentage of Medicaid, bad debt, and charity care gross patient revenues--to agree to release information to Congress relating to the disproportionate-share issue. The AHA also has cooperated with Congress, ProPAC, CBO, and other organizations in seeking a disproportionate share definition and in working out a formula for an adjustment.

The AHA wishes to commend Sens. Packwood, Dole, and Durenberger for their recognition of the problems faced by disproportionate share hospitals and their willingness to consider legislative solutions during this Congressional session.

REVERSAL OF FAVORABLE COURT RULINGS

Three proposals contained in S.1550, a bill introduced by Sen. Durenberger at the request of the Administration, would have Congress overturn hospitals' court victories on medical malpractice apportionment, labor room/delivery policy, and successful base-year appeals. Specific legislative authority would retroactively apply discredited HHS policies on medical malpractice apportionment and labor room/delivery policy, despite determinations by numerous federal district and appeals courts upholding hospitals' positions. These retroactive changes, after hospitals nationwide have faithfully adhered to the Congressionally established process for Medicare dispute resolution, would be blatantly unfair.

The final proposal would prohibit redeterminations of Medicare prospective payment rates based on successful appeals of base-year costs. This provision effectively eliminates judicial review of PPS rate determinations. Proper redeterminations of base-year costs are necessary to preserve equity during the PPS transition period.

OUTPATIENT SURGERY

S.1489, pending before the Committee, would significantly alter Medicare payment for outpatient surgery. The bill would:

- Expand the application of the ambulatory surgery centers (ASCs) payment rule to cover procedures in the hospital outpatient setting;
- Limit payment to the inpatient DRG rate for the same procedure in local hospitals;
- Fold into the ASC rate payment for diagnostic services and prosthetics; and
- Update the ASC rates.

This proposal seeks to extend the pro-competitive PPS which is now in place for most Medicare inpatient services. The AHA supported enactment of PPS in 1983 and has mantained its support for effective market-oriented incentives for greater efficiency in the provision of health care services.

In considering this proposal for outpatient surgery, the AHA faces a dilemma. The hospital portion of Medicare outpatient surgery procedures always has been paid on an average allowable cost basis, utilizing accounting rules that do not identify costs per procedure. Consequently, there is no information available to determine the impact of tying hospital outpatient surgery payment to ASC rates.

The AHA understands the concerns that have prompted introduction of S.1489 and its possible consideration by the Committee in drafting a Medicare bill this year. There are several significant questions that should be resolved before the Committee adopts a new payment policy for outpatient surgery. Among them are:

> Are there differences in the severity of illness, and therefore the intensity and cost of services, between surgery patients in the hospital outpatient and ASC settings?
>
> Should these differences be recognized through payment differentials?
>
> Would existing Medicare cost accounting rules conflict with the provisions of S.1489, so that hospital outpatient departments could not compete on a price basis with ASCs? Would such conflicts run counter to the pro-competitive policy underlying the proposal?
>
> How are medical education costs now allocated to outpatient departments to be paid? Will physician training in outpatient surgery be discouraged?

How will the ASC rates appropriately be modified to include diagnostic services and prosthetics?

The importance of these questions is heightened by the prospect that HCFA soon will expand the list of authorized ASC procedures to 650 from the current 150.

Moreover, in considering whether to make this policy change, the Committee should determine whether HCFA has the staff resources and data capacity to implement a major new policy. Further, the Committee should inquire whether the Medicare fiscal contractors and PROs are able to adjust their procedures under their existing financial constraints.

Therefore, while AHA maintains its support for the concept of prospective pricing, the Association urges the Committee to proceed with caution in considering whether to expand the ambulatory surgery payment policy in this legislation.

MEDICARE PART B APPEALS

The Association seeks modifications in the Medicare program similar to those included in S.1551, introduced by Sens. Durenberger, Heinz, and Chafee. That measure would make urgently needed changes in Medicare appeals process which would work to the benefit of both providers and beneficiaries and make the process more consistent with recent changes in Medicare. A similar proposal, sponsored by Rep. Wyden and supported by the AHA, was adopted by the House Committee on Energy and Commerce as part of its reconciliation package.

Currently, under Medicare Part B, if a claim is denied by a carrier, the beneficiary or provider may appeal to the carrier for reconsideration through the carrier fair-hearing process. However, if the dispute is resolved against the beneficiary or provider, there is no further administrative or judicial review. The AHA supports a procedure whereby disputes involving determinations of entitlement to benefits and amount of benefits will be heard by an administrative law judge. The entity which brings the dispute to the administrative law judge should be able to seek judicial review if it is dissatisfied with the judge's decision. Such a revision of the law would bring greater equity to the appeals process by removing the overwhelming advantage carriers now have in the process.

The AHA also supports a change in the law which would allow provider representation of beneficiaries in appeals proceedings. By an Intermediary Manual change, HCFA recently precluded a provider--hospital or physician--from representing beneficiaries. In denying such representation to beneficiaries, HCFA has eliminated a potential advocate experienced in Medicare procedures and providing services without charge. This change puts beneficiaries at a distinct disadvantage. The AHA urges that statutory authority restoring provider representation of beneficiaries during the Medicare Part B appeals process be included in this Committee's deficit reduction package.

CLINICAL LAB PAYMENT

Section 2303 of the Deficit Reduction Act of 1984 requires Medicare payment for outpatient clinical laboratory services to be made on the basis of fee schedules set at a percentage of prevailing charges of independent laboratories and physicians--62 percent for hospitals and 60 percent for non-hospital providers. Although the Act was signed into law July 18, 1984, the new laboratory payment provisions were made retroactive to July 1, 1984. Interim billing instructions were not distributed to hospitals until September, 1984. The retroactive effective date of this provision, coupled with major changes in reporting requirements necessary for implementation, has created serious operational problems for both Medicare fiscal intermediaries and providers and has resulted in large claims backlogs and payment delays. Yet, more than a year after the passage of Section 2303, no regulations have been promulgated.

Section 102 of the House Energy and Commerce Committee's reconciliation bill, H.R.3101, imposes further limits on payment for outpatient clinical laboratory services. The AHA opposes such a provision since any proposal to freeze or lower the current fee screen would simply lock in the inequities of the present system and severely limit the ability of hospitals to continue to provide competitive, high quality laboratory services. Rather, the AHA would urge this Committee to hold oversight hearings to explore more fully the impact of the new fee screen and examine the need to develop a theoretically sound formula rather than the arbitrary limit now in effect to establish prices. In addition the General Accounting Office has just begun its legislated review of the effectiveness of the 1984 law.

Furthermore, because the charge experience of non-hospital providers was used to establish the basis for prices for hospital outpatient services, actual prices paid have little or no relationship to actual costs. For instance, a task force established by the State of Montana to review the effect of the new laboratory fee schedule found that, based on a sample of 55,848 tests provided between July 1 and December 31, 1984, the 11 Montana hospitals that were surveyed--20 percent of Montana hospitals representing 40 percent of all admissions--were reimbursed $71,485 below their costs and $336,641 below their charges. Preliminary AHA surveys indicate that this disparity between costs and payment is widespread.

The AHA also is concerned about the treatment of laboratory services offered solely by hospitals. When the new laboratory payment system was approved, Congress was not aware that a large number of individual laboratory services offered by hospitals were not provided in other outpatient settings. As a result, no specific provision was included in the legislation for establishing the prices for these hospital-specific procedures. In some states, as many as 75 percent of the tests were unpriced at the time the original fee schedules were released. Because certain procedures are performed only by hospitals, it is appropriate to have fee schedules for these services developed from hospital charges. Obviously, the hospitals are competing for these services in the marketplace with other, similar providers, not independent laboratories.

Also, as Congress has recognized, prices for emergency services should be based on hospital charges because emergency services are provided only in hospital settings. Section 2302 of the Act does permit adjustments or exceptions to the fee schedules to ensure adequate payment for laboratory procedures needed for the provision of emergency services; however, no regulations have yet been issued to allow such adjustments or exceptions.

HOME HEALTH CARE

As a result of the implementation of PPS for hospitals, the home health industry is experiencing an increase in both the volume and intensity of referrals from hospitals. Anecdotal evidence indicates that Medicare patients today require more frequent visits of longer duration than Medicare patients of a year ago and also require proportionately more medical-surgical supplies and durable medical equipment, as well as supportive and technical services. Meeting all of these escalated needs inevitably causes a home health agency's costs to increase. Yet, on July 5, HCFA published final regulations implementing Section 223 cost limits for home health agency services as a method of limiting Medicare payment for these services. If this regulation is allowed to stand, there very likely will be serious consequences for Medicare patients in terms of the quantity and quality of home health services available. The AHA supports legislation (S.1450), introduced by Sen. Heinz, prohibiting the Secretary from changing the current Medicare home health reimbursement methodology before October 1, 1986 or during a freeze on home health payment levels.

Another home health-related bill, S.1402, introduced by Sen. Proxmire, would abolish the 11 percent "administrative and general" (A&G) adjustment to the cost limits for hospital-based agencies. The AHA opposes this legislation.

Hospital-based home health agencies' higher costs result, in part, from the fact that most of their patients come to them immediately upon hospital discharge, and are, in the aggregate, more severely ill than freestanding agencies' patients. Hospital-based agencies also have a larger amount of overhead than freestanding agencies because of Medicare payment guidelines and cost-allocation requirements. The A&G add-on was designed to recognize these legitimate costs. Because of the add-on, these A&G costs allocated to the home health agencies were not included in the hospitals' base-year cost report under Medicare prospective pricing. To eliminate the add-on now would place the hospital-based home health agency program in double jeopardy.

The AHA urges this Committee to support efforts to rescind HHS' July 5 regulatory limits on home health payment and to oppose legislation to eliminate the A&G payment to hospital-based home health agencies.

MEDICAID SERVICES TO PREGNANT WOMEN

The AHA supports Section 201 of the House Energy and Commerce Committee's reconciliation bill, that would mandate Medicaid coverage for prenatal care, delivery, and postpartum care for pregnant women in families in which the husband is employed. Although this provision is estimated by the Commerce Committee to cost $100 million over three years, the Association strongly believes that in the long term funds allocated for such preventive care services will actually save money.

A recently released report by the House Select Committee on Children, Youth and Families--"Opportunities for Success: Cost-Effective Programs for Children"--contends that federal dollars spent to improve the health of low-income children and pregnant women are returned many times over in reduced need for later and more costly care. According to the report, every $1 spent on prenatal care for low-income pregnant women has saved more than $3 in costs of care for low birthweight infants. In Michigan, more than $6 in newborn intensive care costs was saved for every dollar spent, and the Colorado Health Department estimated that $9 could be saved in premature infants' medical costs for every $1 spent on comprehensive prenatal care. The report estimates that comprehensive prenatal care under Medicaid saves $2 for each dollar spent in the first year of an infant's life. In Ohio, Medicaid savings of $250 per child resulted from preventive screening services. The AHA urges members of this Committee to adopt language mandating Medicaid coverage of prenatal services.

EXPANSION OF PROPAC

The Association supports S.984, introduced by Sen. Dole, and cosponsored by Sens. Durenberger, Bentsen, and Baucus, of this Committee, which would increase the membership of ProPAC by adding representatives from rural hospitals and nursing services. As ProPAC has grown in importance, paticularly in making legislative recommendations to Congress as well as to the Secretary of HHS, the rural and nursing constituencies within the AHA have pointed to the absence of ProPAC members to speak up and speak out for rural hospital and nursing concerns. S.984 addresses this lack; its adoption as part of this Committee's deficit reduction package would indicate not only to those in the rural hospital and nursing fields but also to others in the health care industry that Congress is sensitive to the needs of rural hospitals and nursing services under PPS.

LIFETIME LIMIT ON PSYCHIATRIC CARE IN GENERAL HOSPITAL UNITS

A provision in S.1550, introduced by Sen. Durenberger at the request of the Administration, would apply a beneficiary lifetime limit of 190 days to inpatient care provided in general hospitals' psychiatric units, exempt from Medicare prospective pricing under the Social Security Amendments of 1983. The AHA opposes this provision.

In exempting such units from prospective pricing, the Social Security Amendments directed the HHS Secretary--by the end of calendar year 1985--to conduct a study to determine whether psychiatric hospitals and units (and other services excluded from the pricing system) should be paid prospectively, with examination of methods for doing so. Studies--some under contract to HHS--are now being conducted by various organizations on prospective pricing issues. It is the AHA's strong recommendation that no decisions be made as to changes in payment policy for such units until the studies have been completed and their results analyzed and reported.

Although the summary to S.1550 states, "Under current law hospitals have little incentive to limit the length of stay of patients in such units," it is important to note that the hospitals are subject to payment limits for inpatient psychiatric care established under the Tax Equity and Fiscal Responsibility Act of 1982, limits that the HHS Secretary has frozen for FY 1986, in regulations published in the September 3 Federal Register.

The 190-day lifetime limit on inpatient psychiatric care fails to recognize the variation in mental illness, with some episodes requiring brief, recurring stays and others, lengthy, nonrecurring hospitalizations. Moreover, elderly patients with chronic mental illness may have complicating physical ailments that affect treatment of their psychiatric problems.

Various other factors must be considered as well. For example, general hospital units provide active psychiatric treatment, not custodial care, making application of the limit--as an "incentive" for shorter lengths of stay--arbitrary and unnecessary. In addition, denial or interruption of psychiatric treatment can lead to an increase in the use of other medical services, such as acute or skilled nursing facility care, adding to overall Medicare costs.

With studies in process on various aspects of payment for psychiatric care, this is not the time to consider application of the 190-day limit to general hospital psychiatric units. The AHA urges its exclusion from the Committee's deficit reduction package.

CONCLUSION

Medicare, in fact all of health care, is at a critical turning point. With adoption of prospective pricing for Medicare and developments of initiatives in the private health sector, incentive-based approaches are demonstrating that they are effective in containing health costs. At the same time, Congress, HHS, and the health care system must cooperate in assuring that the approaches work efficiently and fairly. The time taken for such assurance need not be accompanied by high increases in health costs. During the past year, under a system largely based on hospital-specific prices, hospitals achieved the lowest rate of increase in costs since 1963, the year in which the AHA began its routine survey of expenses and utilization.

The development of a workable, equitable PPS is made more difficult by the need to deal with the federal budget deficit. The AHA recognizes that hospitals will have to contribute their share to the solution of the deficit problem. However, hospitals and the Medicare beneficiaries they serve should not be required to bear more than their fair share of the deficit reduction effort. In addressing that effort, as well as the issues discussed above, the AHA takes the following approach:

- Any reduction in payment should be the result of Congressional action, rather than of regulatory fiat.

- A reduction in payments should be only for one year, followed by an increase of the hospital marketbasket plus one-quarter of a percentage point, as now provided for in law. Any reduction would create hardships for some hospitals. It must be clear that, if the present system of payment for hospitals, which is working, is going to provide adequate care for beneficiaries, hospital rate increases cannot be limited for more than one year.

- Prospective correction of the area wage index should take place before reductions become effective.

- Because a reduction in payments will exacerbate the anticipated problems of hospitals offering needed, but costly, referral services and treating the most complex mix of Medicare cases, hospitals should be given assurance that they will be paid no less in FY 1986 than they were in FY 1985.

- Due to significant problems with the current system of DRGs and price-setting, immediate attention should be given to the development of an alternative to the planned transition to uniform rates. Uniformity is not necessary to realize the benefits of prospective pricing, as has been demonstrated by the past year's performance. The AHA believes that DRG-specific price blending offers the best method of achieving equity, while preserving the positive incentives of prospective pricing. Not only should price blending be adopted, but work also should proceed on several other issues, including the recalibration of DRG cost weights to reflect more accurately the relative cost of treating patients in each DRG and the development of more accurate labor market definitions.

- The problems of hospitals treating a disproportionately large number of low-income patients should be addressed through the creation of an adjustment to the DRG price schedule. This adjustment could be implemented with minimal impact on the overall federal budget deficit, and would protect hospitals that are critically needed by their communities.

The AHA also urges this Committee to give favorable consideration to proposed changes in Medicare Part B appeals, to suggested changes in coverage of Medicaid pre-and post-natal services, and to expanding the membership of ProPAC to include respresentatives of rural hospitals and nursing services.

In addition, the AHA opposes the provisions of S.1550 that would nullify favorable court rulings on medical malpractice apportionment, labor room/delivery policy, and successful base-year appeals, as well as the provision limiting lifetime coverage of inpatient psychiatric care.

Further, the Association opposes eliminating the administrative and general adjustment to the cost limits for hospital-based home health agencies and the regulatory limits placed on health reimbursement.

Finally, the AHA urges the Committee to consider carefully a number of significant questions concerning the payment policy for outpatient surgery.

STATEMENT OF MICHAEL BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS, WASHINGTON, DC

Mr. BROMBERG. Thank you, Mr. Chairman.

In the interest of time and brevity, I am going to try to beat the yellow light by summarizing just a very few points of this testimony.

For 20 years, since our organization was formed in 1966, we have come to the Hill and testified in favor of prospective payment. We finally got it a couple of years ago, and we still support it, but we would like to note that we support it with a fair rate of increase and a continued transition to the national rate, the two going together.

You have heard stories this morning about savings: $2.2 billion in lower Medicare costs than projected by the trustees of the program last year alone, the lowest hospital rate of increase in 20 years, and what do we get for it? The proposal for a freeze.

The field thinks it is unfair. We think it is unfair, basically because we think we have kept our part of the contract and the bargain that was implied when we supported this legislation before Congress 2 years ago. And a freeze would not reward those managers who have taken the hard actions they have taken by laying off workers, cutting costs, postponing modernization of plant and equipment.

And if they have to do those things again, one day it will impact quality. We are not ready to cry "wolf" yet, and tell you quality is suffering. It isn't. We are doing fine under this program, but you can't keep freezing our rates and expect that to continue.

The second issue that we would like to mention that is of particular importance to our industry, of course, is the highly emotional one of return on equity. We are very much opposed to the action taken by the House to eliminate it a year from now.

We think that the whole capital issue is a very complex one. You are awaiting a report. We favor moving ahead with some kind of capital bill, but to single out one element of capital and leave all the others pending, we think, discriminates against investment.

For example, if you did that, you would be telling my members that they can go out and borrow money from a bank and Medicare will gladly pay them the interest, but they shouldn't go out and raise it from investors because then there would be no return.

We would like you to look at capital in the context of all those issues.

We support what has been said about the wage index not being retroactive. We support what the committee has done on disproportionate share.

I would like to mention something about Senator Durenberger's bill, S. 1489. We do not oppose the bill, and I think we are ready to support it; but we would like to strongly suggest that the committee do for it what it has done for prospective payment: have some kind of a transition.

I don't think we need a 3-year transition. I think two years would be perhaps appropriate, plus some recognition that there is a differential in cost. But with those changes we would not oppose Senator Durenberger's bill.

I would like to mention just briefly the fact that over 30 courts in the country, including 24 U.S. district courts and 6 courts of appeal, have ruled in favor of hospitals on the malpractice issue; and the administration has requested some legislation to overrule all those cases, as well as some other cases.

And we would hope the committee would not take that kind of drastic action without looking at it. We think that on the merits, they are wrong. The courts thought they were wrong. The data is old, and there is no justification for saying that Medicare-paid claims in the malpractice area would result in lower premium costs if the Department had its way.

In conclusion, we are concerned about the fact that you have probably the most successful program ever enacted by Congress and the administration with the support of an industry 2 years ago, and our major fear is that you might take some steps which would undermine the support of the field for that program.

And with that one thought in mind, I will stop the testimony at this point.

The CHAIRMAN. Thank you, Mike. Dr. Willging.

[The prepared written statement of Mr. Bromberg follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Summary

The Federation of American Hospitals has supported and continues to support implementation of the prospective payment law as passed with fair rate increases and a continued transition.

Hospitals have responded to the new incentives of the prospective payment system by saving the Medicare program billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price.

The Board of our association has not taken a position on the transition coupled with a rate freeze because to do so might convey the impression we might accept a rate freeze as equitable, which we do not. Instead we urge the members of the Committee to authorize a fair rate of increase in hospital payments for Fiscal Year 1986 in order to ensure the continued success of the Medicare hospital prospective payment system.

Medicare's return on equity payment is identical in principle to the payment of interest expenses incurred by not-for-profit hospitals. Return on equity like interest is a cost. The Medicare return on equity and other capital issues should be analyzed as part of the development of a prospective payment plan for Medicare capital payments for all hospitals.

The new wage index developed by HHS should be prospectively implemented and not made retroactively effective. The Department should continue to refine the wage index to reflect accurately the labor costs of individual hospitals.

We applaud the efforts of the Committee to address the needs of hospitals serving a disproportionate share of low-income patients and we support appropriate criteria to determine which institutions are eligible for a "disproportionate share" adjustment. A long term solution to this problem may be the development of an accurate severity index. Furthermore, Congress must in the near future address the broader issue of uncompensated care affecting all hospitals.

We support the concept of prospective payment for outpatient surgery and we would not oppose the approach of S.1489 introduced by Senator Durenberger provided it is amended to include a phase-in or transition period and a price adjustment to recognize the average actual costs of hospital outpatient departments.

We oppose the Administration's efforts in S.1550 to ratify regulations issued by the Health Care Financing Administration, but held invalid by the Courts, concerning direct apportionment of malpractice costs to Medicare and inclusion of labor or delivery room days in determining hospital per diem costs. Such action would result in the Medicare program not paying its appropriate share of costs generated by Medicare patients.

The Federation of American Hospitals is the national association of investor-owned hospitals and health care systems representing over 1,200 hospitals with over 140,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

DRG Rates and Transition

The Federation of American Hospitals has supported and continues to support implementation of the prospective payment law as passed with fair rate increases and a continued transition. Hospitals have responded to the new incentives of the prospective payment system by saving the Medicare program billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price. Due to the more careful management of admissions, labor costs, and utilization of facilities, the hospital industry has succeeded in bringing hospital costs down dramatically. In 1984, the annual rate of increase in hospital expenditures was only about 4.5%, or approximately the same as the general inflation rate. Clearly, the Medicare hospital prospective payment plan is working. Hospitals have responded to the new incentives by cutting their expenditures. In fiscal

1984, for example, actual Medicare Part A spending was 6 percent or $2.2 billion less than originally projected by the trustees of the Hospital Insurance Trust Fund.

Hospitals have demonstrated that with the appropriate incentives they will vigorously cut costs. However, the right incentives under this system include an equitable rate of increase in payments from year to year. If hospitals feel their only reward for reducing hospital expenditures is to receive a freeze in future payments, there remains little reason for their continued support of the program.

Hospitals understood the prospective payment law to be a contract. We have kept our part of the contract, and the system is working. However, if Congress unilaterally changes this contract by freezing hospital payments, then hospitals can hardly be expected to continue to endorse the program. Instead, you will have calls for the continuation of cost based reimbursement, with all of its perverse incentives and lose the opportunity to move forward with a program that has allowed the Medicare Trust Fund to remain solvent a decade longer than predicted just a year ago and has benefited private insurers, beneficiaries and employers as well.

A freeze in hospital payments will not reward hospital managers who have cut their costs by working with their staffs, physicians and patients to adapt to the new payment system. Instead hospitals will be forced to reduce their intensity of services to Medicare beneficiaries, cut their staffs and wages, postpone replacement of equipment and plant modernization, increase prices to non-Medicare patients and increase charges to Medicare patients for non-covered services.

We believe that a rate increase at least as much as that recommended by the Prospective Payment Assessment Commission should be enacted, coupled with language to "prohibit" the Department from implementing a net increase in rates lesser than that mandated by Congress. The Federation of American Hospitals believes the hospital industry should accept a fair share of responsibility in any attempt to reduce the Federal deficit; however, a freeze in hospital payments goes far beyond any sense of fairness and proportion and should be rejected.

The Board of our association has not taken a position on the transition coupled with a rate freeze because to do so might convey the impression we might accept a rate freeze as equitable, which we do not. Instead we urge members of this Committee to legislate a fair rate of increase in hospital payments to ensure the continued success of the Medicare hospital prospective payment system.

Medicare Return on Equity

Congress, in enacting the Medicare Hospital Prospective Payment System, did not include capital costs, but continued to reimburse hospitals for capital expenditures on a cost basis. Congress also directed the Secretary of HHS to complete a thorough review of the methods by which capital, including return on equity (ROE), could be be incorporated into the prospective payment system. Any change in return on equity payments prior to consideration of a prospective payment system for all capital payments to hospitals would be inappropriate.

The issue presented here is whether to reduce or eliminate Medicare return on equity payments to the owners of investor-owned hospitals for the use of their equity capital to finance hospital buildings and equipment used by Medicare patients.

Medicare currently pays a rate of return on equity of less than 12%, a rate considerably lower than that earned by industries of comparable risk. The Medicare program also reimburses the full interest expenses associated with capital expenditures by hospitals. For example, if a hospital borrows $10 million to finance a project, the interest on the entire amount is reimbursable. If an investor-owned hospital finances the same $10 million dollar project by borrowing $6 million and raising $4 million through an equity offering, it should receive reimbursement for the cost of the equity capital. To do otherwise would simply discriminate against invested capital in favor of borrowed capital.

Medicare's ROE payment is identical in principle to the payment of interest to people who have loaned money to not-for-profit hospitals. Like interest, return on equity itself is a cost. Both interest and return on equity are compensation to the suppliers of capital for the right to use it. Failure to pay interest on debt would be considered using somebody else's money without paying them for it. Failure to pay return on equity has the same effect.

A further element is the income tax liability that is the responsibility of the investor-owned hospital. It pays a corporate federal and state income tax on its net income which reduces the pre-tax Medicare return on equity payment by approximately 41 percent. Investor-owned hospitals also pay state and local property taxes. Investor-owned hospitals cannot issue tax-exempt securities to finance capital expansion and may not receive grants and tax deductible gifts. Therefore, without a return on equity payment, investor-owned hospitals would be at a clear competitive disadvantage.

The owners of debt capital and the owners of equity capital are identical in that both are suppliers of an essential resource, and like suppliers of another essential resource, labor, they are entitled to a return for the use of that resource. To eliminate the ability of investor-owned hospitals to recoup equity costs from Medicare would arbitrarily single out and penalize one segment of the hospital industry.

The capital assets of the investor-owned hospitals represent a 20 billion dollar investment in our health care system. Congress has already cut reimbursement for return on equity by one third, during enactment of the prospective payment system in 1983. If their ability to raise equity capital in a competitive environment is impaired, new capital will not be available for needed future investment. Use of debt capital by investor-owned hospitals, which have severely restricted access to tax exempt financing, could cost the Medicare program more than it currently reimburses for return on equity.

The Medicare return on equity and other capital issues are complex parts of an important area of reimbursement and should not be changed prior to careful study. Return on equity should be analyzed, as directed by Congress, as part of the development of a prospective payment plan for Medicare capital payments for all hospitals.

Wage Index

The new wage index developed by the Department of Health and Human Services appears to reflect more accurately hospital labor costs, particularly for hospitals using part time employees. The HHS data base represents a more complete survey of hospitals. The new wage index also appears to lessen the effects of the transition to a national prospective rate, after revision of the standardized amounts to account for the changed wage index.

We believe the new wage index should be prospectively implemented this coming fiscal year, and not made retroactively effective. Hospitals cannot plan effectively for retroactive changes in payment. Retroactive application of the new wage index could severely undermine the fiscal predictability critical to the prospective payment system.

The Department of Health and Human Services should continue efforts to refine the wage index so that it accurately accounts for prevailing wages in a hospital's particular labor market area. The Deficit Reduction Act of 1984 directed the Secretary to develop criteria by which an adjustment could be made in a hospital's wage index if it did not accurately reflect the hospital wage levels in the labor market area serving the hospital. We encourage the Secretary to develop the criteria to ensure that individual hospitals receive a fair wage index adjustment.

Disproportionate Share

We applaud the efforts of the Committee members to address the needs of hospitals serving a disproportionate share of low-income patients and Medicare Part A beneficiaries as called for in the original prospective payment legislation. We hope the Committee, in conjunction with the Department, will develop appropriate criteria to determine which institutions meet the definition of "disproportionate share" hospitals incurring higher costs due to their patient population. However, while this may prove to be a necessary short term adjustment, the development of an appropriate measurement of severity would serve as a long term and more equitable solution for all hospitals serving a population requiring greater intensity of services. We would encourage the Department to develop a severity index rather than developing a complex system of exceptions and adjustments for select hospitals. Since factors such as bed size, urban area population, and proportion of low income patients served are useful mainly as proxies for patient health status, the adjustment of payment rates by an objective, direct measure of health status would make the need to use such proxies unnecessary.

We would further point out that solving the problem of "disproportionate share" hospitals does not address the larger issue of uncompensated care, a burden borne by every hospital. The evolution of a competitive health care system intensifies the magnitude of the uncompensated care problem. Congress must turn its attention towards this critical matter and realize that the adjustment in Medicare payments for disproportionate share hospitals does not address the issue of hospitals providing care without receiving payment from any source.

Outpatient Surgery

Some reports have implied that the Medicare Program pays hospitals the charges which they bill for outpatient services on the Medicare Claims Form. Hospitals, however, are reimbursed the lower of reasonable costs or charges for outpatient services as determined on the cost report.

For example, part of Inspector General Kusserow's Congressional testimony on July 19, 1985, dealing with reimbursement for intraocular lenses is misleading. If the hospital bills charges of $250 - $790, Medicare will not pay $250 - $790. Medicare will pay within the range of $175 - $400, which is the hospital's cost. Thus, there is no markup that is received by the hospital.

We recommend that payments to hospitals be based on rates determined using a combination of hospital outpatient cost data and Ambulatory Surgical Center (ASC) data instead of only ASC information. A phase-in approach could be taken similar to inpatient PPS whereby a portion of the total is based on a declining percentage of hospital outpatient costs over a specified period of time. At the minimum, Congress should provide exceptions in situations where hospital outpatient departments are the only outpatient delivery alternative for beneficiaries.

The proposed implementation date of January 1, 1986 does not provide enough advance time to collect the necessary data, determine the rates, and revise hospitals and intermediary billing systems. Many problems (e.g., claims processing backlogs, recordkeeping requirements, and computer system changes) were created last year when Congress enacted the outpatient clinical lab fee schedule provision effective July 1 with no advance preparation time.

We recommend that more advance preparation time be given prior to implementation. Consideration should also be given to phasing in the provision based on hospital cost report beginning dates.

Presumably, the all inclusive payment rate for certain prosthetic devices such as intraocular lenses and other items would be based on an average or standard cost. If the beneficiary requests items more expensive than the "standard model," hospitals should be permitted to charge the beneficiary for the difference between the "standard model" and the "luxury model." If the more expensive items are medically necessary, hospitals should be permitted to recoup the additional costs of these items from the Medicare Program.

Direct Apportionment of Malpractice Costs to Medicare

The Federation opposes the direct apportionment of malpractice costs to Medicare, as proposed by the Administration in S.1550. We strongly urge withdrawal or rejection of this provision. Its stated purpose is to ratify retroactively to July 1, 1979, regulations or instructions issued by the Health Care Financing Administration that have been held invalid by numerous U.S. District Courts and U.S. Courts of Appeal. Enactment of this section would unfairly and arbitrarily select one and only one cost element of a hospital's administrative and general expenses for a different determination of the government's share of the hospital's overall costs for services rendered to Medicare patients than on the basis of the ratio of Medicare utilization to total utilization. Endorsement of such a different policy would inevitably leave hospitals no recourse but to claim through reimbursement appeals and litigation such costs as preparation of complicated cost reports that hospitals now incur to provide Medicare services but which are now paid for on a Medicare utilization basis.

Inclusion of Labor or Delivery Room Days in Determining Hospital Routine Inpatient Per Diem Costs

The Federation also urges withdrawal or rejection of the Administration's proposal in S.1550 for inclusion of labor or delivery room days in determining hospital routine inpatient per diem costs. Again, this proposed section would ratify retroactively regulations and instructions issed by HCFA in anticipation of and in response to unfavorable rulings by numerous U.S. District Courts and U.S. Courts of Appeal on the method of calculating Medicare's share of a hospital's costs. Enactment of this section would have no other purpose than to shift costs that properly should be borne by the Medicare program to non-Medicare patients and their insurers. This practice, since the original enactment of the Medicare program in 1965, was explicitly prohibited in the law, and continues to be a well-founded intent of Congress.

Conclusion

The Medicare Hospital Prospective Payment System is the most effective cost containment program ever enacted, successful beyond anyone's expectations. Last month we testified before this Committee on the Administration's budget proposals for Fiscal Year 1986, specifically the freeze in hospital payments. We asked this Committee to enact a fair rate increase in payments to hospitals by urging the House Budget Committee to reduce its target for Medicare cuts.

We again urge the members of this Committee not to undermine the success of this program through arbitrary, inequitable reductions in payments to hospitals.

STATEMENT OF PAUL WILLGING, PH.D., DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. WILLGING. Thank you, Mr. Chairman. I represent the American Health Care Association with over 9,000 long-term care facilities in this country, very few of whom participate in the Medicare Program. The nursing home industry is very interested in the Medicare skilled nursing home benefit. There is an access problem. Patients are being discharged sicker and quicker from hospitals. And the problem we face is that Congress, while fixing half the equation by dealing with reimbursement for hospitals, did not address the other half of the equation, the ability of providers to accept those patients.

We are very pleased to have been able to work with staff of the Senate Finance Committee over the last few months in trying to rectify at least a part of this problem by developing a prospective reimbursement system, at least for low-volume Medicare skilled nursing facilities, which will provide for the actual availability of SNF beds under Medicare.

As long as there are States which have no more than one or two participating SNF providers in Medicare, we clearly have a program which exists only in statute, but not in reality.

We would also like to suggest that reimbursement is only part of the problem of access. The beneficiaries under the Medicare Program are to a considerable extent being held hostage to the inadequate coverage guidelines and systems in place within the Health Care Financing Administration.

There has been, up to this point at least, the presumption that a provider—SNF, Home Health—is in fact providing adequate coverage determinations, as long as the error rate does not exceed 5 percent.

HCFA had tried through regulation and is now trying to do through administrative action what it did not do through regulation—essentially wipe out that presumptive status.

We would propose a freeze on such further activities by HCFA. We are looking to the possibility of front-end review so that the beneficiary is not, in the future, caught twixt and between and knows in advance whether the condition following hospital discharge would in fact be covered under Medicare.

We are also suggesting that we might want to look to designating specialists among the intermediaries to make sure that this arcane art called coverage determination is not spread across 50 or 60 intermediaries but perhaps can be limited to a more reasonable number.

We would also suggest that this committee take another look at the 3-day prior hospitalization requirement. A figure of 3 days may or may not have been adequate 10 or 15 years ago, but medical science has advanced. Such things as cataract surgery, even hip fracture, which might in the past have occasioned 5, 6, 7 days of a hospital stay no longer do. Perhaps prior hospitalization should still be a requirement but need it be 3 days?

I would like also to just briefly indicate our support for Senate bills 1378, 1249, 1551, the Long-Term Care Insurance and Protection Act, the Home Respiratory Care Act, and the Fair Medicaire Appeals Act, all of which would provide advantages in terms of both dollars and the rights of Medicare beneficiaries to receive the services to which they are entitled.

Finally, I would like to chat very briefly about a provision passed last year. From our perspective, we would characterize it as the infamous section 2314, which imposed restrictions on revaluation of provider assets under the Medicare and Medicaid programs.

For the hospital industry, since most of the revenues from public programs come from Medicare, restrictions on asset revaluation will be a temporary phenomenon since Congress is intent on dealing with capital for the hospital industry. For reasons that still elude me, that provision will be permanent insofar as its applicability to nursing homes participating in Medicaid.

It essentially tells the nursing home owner that the facility they constructed or purchased 10, 15 or 20 years ago is worth today what it was worth then. It is, from my perspective, a perverse piece of public policy, and it is not a question of proprietary versus nonproprietary owners. It is not a question of large versus small. It is a question of basic economic reality.

And indeed, the perverseness comes in the fact that it is precisely that owner who has maintained the facility for 20 years and who has served nothing but Medicaid patients who is most aggreviously disadvantaged by that provision.

We would suggest that the results will be inevitable. There will be poorer quality. There is no incentive to maintain a physical plant and capital resources if the individual is never going to be able to realize the market value of that facility.

We are proposing an alternative. We are proposing a restriction on the amount that the asset can be revalued so that the abuses that might have led to concerns in the past would be alleviated.

But we are suggesting that, if we are to attract into this industry the capital that we need to build the beds that clearly will be required as a result of the demographics, we need a compromise position on the asset revaluation provision.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Armitage.

[The prepared written statement of Dr. Willging follows:]

STATEMENT OF PAUL WILLGING, PH.D., DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and Members of the Committee:

I am Paul Willging, Deputy Executive Vice President of the American Health Care Association. AHCA is the largest organization of long term care providers, representing about 9000 nursing home-based providers.

I appreciate the opportunity to present our views and recommendations on Medicare and Medicaid issues before the Committee.

MEDICARE

On April 17, I described to the Committee how the Medicare skilled nursing facility (SNF) system is broken, but repairable. I am very pleased with Committee members' responsiveness to the access problem.

The problem of patient access to needed SNF services, already acute in many areas of the country, is worsening because of hospital-DRG incentives for more patient transfers to SNFs and earlier transfers involving sicker patients. Some of the numbers about geographic disparities in Medicare SNF availability bear repeating:

- Only 25 percent of the SNFs are in rural areas
- 30 percent of SNF patient days are concentrated in 2 states, 50 percent in 6 states

- 9 percent of the SNFs provide fully 40 percent of patient days and 40 percent of the SNFs provide only 9 percent of the patient days
- Beds per 1000 elderly beneficiaries range from 1 (Arkansas and Oklahoma) to 51 (North Dakota)
- Patient days per 1,000 elderly beneficiaries range from 1 day (Wyoming) to 635 days (Kentucky)

1. SNF prospective payment system

The primary barrier to Medicare patient access is the burdensome and inefficient reimbursement system for SNFs that acts to discourage facilities from choosing to participate in Medicare. When I last testified, AHCA's proposal for a transitional approach toward prospective payment was presented. With the strong interest of Senators, much progress has been made toward developing a proposal for prospective rate setting for SNFs with low Medicare involvement, defined as having less than a threshold number of Medicare patient days per year. Although encouraging greater involvement from "low volume" facilities is crucial for improving patient access, modest changes for the other SNFs are needed and can be easily implemented.

With regard to the many SNFs which have only a small number of Medicare patients, we have four recommendations:

- The threshold level should be set at between 2000 and 2500 annual Medicare patient days, an average of about 6 patients per day. Although only 25 percent of Medicare patient days are accounted for by below-2000 SNFs, this threshold would serve almost 2400 facilities.

- A regional payment rate for the below-threshold facilities should be based on the cost experience of the above-threshold facilities. Costs reported by low Medicare volume facilities understate the true incremental costs of caring for Medicare patients because of the cost averaging procedures.

- Cost reports by these below-threshold facilities should be eliminated. This will remove one of the major barriers to SNFs participating in Medicare and unnecessary administrative cost.

- Capital should be included in the rate by folding in reported capital costs either with return on equity as presently constituted or by replacing return on equity (which is paid only to proprietary facilities) with a 6 percent add-on to reported capital costs for all facilities.

We also urge progress be made toward moving the SNFs with above-threshold volume onto prospective payment. A prospective approach could easily be added to the present system. A facility-based prospective rate could be set annually by indexing forward a facility's costs for all operating and most direct patient care expenses, up to a ceiling fixed by the costs of comparable facilities. For ceiling computations, facilities should be grouped by absolute levels of Medicare patient days and geographic regions, similar to the existing "Section 223" limits on routine costs.

To introduce continuing cost containment, an efficiency incentive payment should be made for SNFs that keep their costs below the ceiling. The incentive should be about one-half of the rate-ceiling difference, which would be large enough to influence providers and still return savings to Medicare (the taxpayer). Total incentive payments could be limited to discourage cost reductions which would result in an adverse impact on quality of care.

These reimbursement reforms would be a very constructive and reasonable approach to improving patient access by attracting needed SNF participation. They would serve as stark contrast to the provision devised by the House Ways and Means Committee to for short-run, short-sighted budget cutting by reducing the financial rate of return on equity investments in Medicare SNFs.

2. Waiver of liability

Last March, the Health Care Financing Administration proposed eliminating the "waiver of liability", a provision which allows relief to a provider who acted in "good faith" in accepting and providing services, later considered by the intermediary to be not reasonable or necessary. Since the coverage criteria is very subjective and intermediary determinations are inconsistent, it is unreasonable to financially penalize providers for their "good faith" efforts in providing care.

Futhermore, HCFA recently changed the way it calculates waivered days. Previously, a SNF's denial rate was calculated by dividing the number of Medicare days provided into the number of days denied by the intermediary. If this figure was below 5 percent, then the nursing home was able to maintain its waiver and the denied days were paid for by Medicare. The new methodology, rather than using the total number of Medicare days in the denominator, uses a sample of cases to project a denial rate. Too often these samples are not at all representative or random, for they focus on the "grey area" cases. Within the last 6 months, scores of facilities have lost their waivers for the very first time as a result of these changes.

We strongly urge a "freeze" on current waiver of liability regulations and instructions until a reasonable approach can be developed. This is a very important issue to retaining and attracting

Medicare SNF participation, especially "low volume" facilities. The current waiver is critical because it provides some protection against the kinds of retroactive denials of coverage that motivated over one-half of the SNFs participating in Medicare to leave the program. The waiver of liability guidelines were passed by Congress in 1972 in direct response to this provider exodus.

One solution that we propose is the reinstitution of front-end review in which the intermediary approves coverage for a patient at the beginning of his stay for a specific number of days. Recertification would take place for additional days if appropriate. This approach was used with some success about 10 years ago and since it affords both patients and providers some measure of protection against retroactive denials, we believe it is worth considering.

We suggest a subcommittee hearing for purposes of hearing from beneficiaries, providers, HCFA and another interested parties before far-reaching changes are permitted. At a minimum, the Administration should not be able to essentially do by regulatory change what Congress has repeatedly refused to do statutorily--repeal the waiver of liability.

3. Designation of "SNF specialist" intermediaries

We support the objective of changing the coverage determination process to reduce the uncertainty and inconsistency in intermediary decisions, as indicated by our above stated interest in some type of prior authorization for coverage.

We recommend an approach that would increase both consistency of coverage determinations and economy of claims processing -- directing HCFA to designate a small number of intermediaries as SNF "specialists". These specialists would be the focus of HCFA training, instructions, etc. and serve as "magnet" for consolidation of provider claims. The provision could also direct a minimum volume of SNF claims be established for an intermediary to serve this function. (The "specialist" approach could also be used for other Part A or B provider categories.)

Proposals to greatly reduce the number of intermediaries to 10 and regionalize claims review would reduce inconsistent determinations. But unless a broad and simple exceptions process was included to accommodate other constructive reasons for intermediary arrangements (e.g., inter-"regional" providers, hospital-based units, computerized claims hook-ups, years of working together), the imposition of 10 regional intermediaries may cause more problems, and unnecessary disruption, than it is suppose to remedy.

4. Minimum 3-day prior hospitalization requirement for SNF services

Much to the frustration of Medicare patients in need of SNF services, HHS has not chosen to exercise its discretionary authority, provided by Congress in 1982, to identify circumstances in which a minimum 3-day hospitalization is unnecessary and costly. We recommend that this inertia be overcome by directing the Secretary to establish, for intermediary use in approving coverage, categories which would not require 3-day prior hospitalization and criteria so intermediaries could request a waiver in particular situations.

5. Long Term Care Insurance Promotion and Protection Act, S. 1378

Private insurance offers a promising approach to purchasing quality long term health care. During the past year, two major barriers have been overcome in developing private long term care insurance with the development of actuarially sound policies and the establishment of affordable premiums. The challenge is to stimulate effective marketing of new products. There are three keys to marketing: 1) consumer education, 2) consumer confidence, and 3) credible coverage.

The process of consumer protection established under the Long Term Care Insurance Promotion and Protection Act (S. 1378) helps in all three areas. We commend Sen. Durenberger and his co-sponsors from this Committee, Senators Roth and Chafee, for their leadership in promoting the concerns of the consumer in this emerging market.

First, the HHS Secretary would develop model LTC insurance standards, in consultation with insurers, senior citizen groups, state insurance commissioners and long term care providers. The standards would include such consumer protections as defining minimum benefits and "pay-out" ratios.

Second, the bill would extend to LTC insurance the process successfully developed for voluntary certification of policies supplemental to Medicare, so called Medigap insurance. For marketing in states which do not enact these or higher standards, a voluntary federal certification would be available to insurers for policies which met the standards. The Medigap provisions for criminal penalties for insurance agents who attempt to use fraud, forgery, or misrepresentations to sell policies would also apply.

S. 1378 initiates a process which takes us through the development and into the implementation of meaningful consumer protection standards. Federal expectations of consumer protection would be strongly conveyed in the passage of such legislation. It would be a catalyst for the National Association of Insurance Commissioners to speed up work on their model standards for long term care insurance. The states which are already working on regulatory issues could be assisted by Federal developments.

We are pleased that the House Committee on Energy and Commerce included a version of this legislation in its Medicare-Medicaid reconciliation package and urge this Committee to also act.

6. Home Respiratory Care Act, S. 1249

AHCA supports the Home Respiratory Care Act, introduced by Sen. Heinz, with co-sponsors including Senators Grassley and Mitchell from this Committee. This bill cuts Medicare-Medicaid spending, while improving patient access to needed care, by creating nursing home and home care opportunities for ventilator-dependent persons who would otherwise continue costly hospital stays. Medicare and Medicaid should take financial advantage from the increasingly improving technology for ventilator care outside of hospitals. Often these patients can be cared for in SNFs for several hundred dollars per day less than hospitals!

This bill is important for removing several Medicare barriers to progressing patients from hospitals to skilled nursing facilities, as soon as medically appropriate. We have a small number of member facilities that currently provide this specialized service under Medicaid, but cannot get Medicare coverage.

7. Fair Medicare Appeals Act, S. 1551

AHCA supports the Fair Medicare Appeals Act introduced by Sen. Durenberger, with Senators Heinz and Chafee co-sponsoring, which includes an important clarification that to secure their rightful Medicare coverage through the claims appeals process Medicare beneficiaries may be represented by the service provider. Many Medicare beneficiaries, because of such situations as their own impairments or lack of family support, are unequipped to battle the cumbersome, intimidating bureaucratic process.

MEDICAID

1. Revise asset revaluation freeze

As you know, the Medicaid program is a much more important factor than Medicare in regard to the present and future delivery of nursing home services. Although the previously discussed issues are important for patient access, they are dwarfed by the adverse consequences of the asset revaluation freeze under Medicare and Medicaid, hastily enacted last year.

In practice, "asset revaluation" has come to be comparable to a "rent" freeze -- a federally imposed "rent" freeze of indefinite duration on nursing homes (and hospitals) under Medicare and Medicaid. These programs no longer recognize actual and legitimate capital costs and the economic reality of asset appreciation.

Let me give a simple example of what asset revaluation means to a nursing home provider. A nursing home may have been built some 25 years ago at a cost of $500,000. As the owners of that nursing home prepare for retirement and look to transfer ownership, their asset will continue in the eyes of Medicaid and Medicare to be worth, at a maximum, only that same $500,000.

What we urge is that the Committee revise the Medicaid capital provisions to allow states to reasonably limit asset appreciation in a way which essentially preserves the amount of Medicaid savings Congress originally sought.

Nursing homes have experienced a wide variety of Medicaid limitations on capital cost reimbursement and a total freeze is the most counter-productive. Perversely, a freeze hits hardest on those providers who are doing what is sought. The longer one has owned a nursing home and the more Medicare or Medicaid patients served, the more penalized they are.

Patient access is adversely affected by the freeze. In the short-term, it serves to discourage care for Medicare and Medicaid patients. In the long-term, private capital investment will be less available and affordable to provide the growth in bed supply needed just to keep pace with the rapidly growing elderly population.

New York Medicaid has had such a freeze since 1977 and now faces a critical shortage of nursing home beds. New York not only had the lowest growth of Medicaid nursing home beds for the period 1976-1980 but the highest number of Medicaid patients waiting in hospitals for nursing home beds, according to a 1983 GAO report. Furthermore, providers avoid new investments in high Medicaid areas. The state's Health Planning Commission has documented inappropriate hospital placement in excess of 4,000 patients per day costing Medicaid nearly five times the nursing home per diem. Because of this shortfall, New York purchases bed space, at premium rates, in adjoining states. In Connecticut alone there are nearly 1,000 patients paid for by New York.

Quality of care is adversely affected by the freeze, also. Providers who choose to participate in Medicare and Medicaid find perverse economic disincentives to maintain and improve the physical plant. If the economic value of an asset cannot be realized, there is no incentive to maintain that asset in quality condition.

Most state Medicaid programs were effective in controlling capital payments through either direct restrictions on capital costs or overall limitations on facility payment rates, such as prospective payment plans which intrinsically control capital costs. Specifically, most states were effective in eliminating artificial increases in reimbursement which may result from sales of facilities.

However, the way the asset revaluation provision was quickly drafted and is being enforced, the "state flexibility" Congress thought it was leaving has been eliminated. It now looks as if no state reimbursement method will be left untouched by the far-reaching freeze. AHCA strongly supports state Medicaid capital methods, supposedly protected by Conference Report language, for which nursing home sales transactions are essentially irrelevant, notably fair rental systems. But even they are being unraveled.

Recognizing the concern that the federal government should prevent increases in Medicaid spending for artificial inflated and unreasonable valuations of capital assets when a facility is sold, we strongly urge the opportunity for more reasonable and equitable controls over capital reimbursement in the Medicaid program.

Specifically, we propose a Medicaid requirement that states' nursing home reimbursement method limits the average increase in the valuation of capital assets, upon change of ownership, to no greater increase than a widely accepted index of nursing home construction costs. The index would not determine a state's revaluation method, but would serve as an "upper limit" on a state's method.

2. Medicare upper limit restriction on Medicaid reimbursement

We urge the Committee to address the linkage between Medicaid and Medicare rate setting as currently reflected in the Medicare upper limit test. While we believe no such artificial connection should exist between the programs, if politically necessary to continue the connection, the definition of the Medicare upper limit should be clear and precise to avoid the current ambiguous situation which permits varying interpretations by HCFA and state Medicaid officials. The simplest way to accomplish this is to codify original Congressional intent as stated in the Finance Committee report language which accompanied passage of the "Boren Amendment" in 1980:

> "The Secretary would be expected to continue to apply current regulations which require that payments made under State plans do not exceed amounts which would be determined under the medicare principles of reimbursement. Since States would be free under the bill to establish payment rates without reference to medicare principles of reimbursement the Secretary would only be expected to compare the average rates paid to SNF's participating in medicare with the average rates paid to SNF's participating in medicaid in applying this limitation." [emphasis added]

As always, I appreciate the opportunity to testify about our views and am encouraged that the Committee may be on the verge of significant progress for nursing home patients.

STATEMENT OF ROBERT D. ARMITAGE, EXECUTIVE DIRECTOR, BOARD OF SOCIAL MINISTRY, ST. PAUL, MN; ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. ARMITAGE. Thank you. Mr. Chairman and members of the committee, I am Robert Armitage, executive director of the Board of Social Ministry in St. Paul, MN. We are a Lutheran multifacility sponsor, owning and operating seven nonprofit, long-term care campuses in Minnesota.

I am here today representing the American Association of Homes for the Aging, otherwise known as AAHA, a national nonprofit association representing 2,700 nonprofit providers of long-term care, health services, housing, and community services for the elderly.

On behalf of AAHA, I would like to thank the committee for providing this opportunity to testify. First, AAHA commends the Congress for rejecting the Medicaid cap proposal and makes the following recommendations with regard to the Medicaid Program.

AAHA urges the committee to maintain the current law on the revaluation of assets, limitations which help to save Federal dollars without adversely affecting patient care.

We are very concerned about reports that the committee may change current law by proposing to once again permit nursing homes to revalue assets upon sale or merger. We understand this proposal is estimated to cost $116 million over 3 years. Such a plan would return us to a time which encouraged rapid turnover of nursing homes.

Equity must be recognized, but care must be directed to prevent a motivation to buy and sell. Our full statement details our concern and offers a much preferred fair market rental alternative.

We strongly urge the committee to reconsider this ill founded proposal which would only cost the Federal Government unnecessary dollars and which promotes a lack of commitment to the continuous provision of quality patient care.

Second, we recommend that the committee make changes in the Medicaid Home and Community-Based Services Waiver Program, which addresses problems in HCFA's overly harsh administration of the program and which would move toward making waiver services optional under the Medicaid State plan.

As a minimum, we encourage you to adopt the relevant provisions contained in H.R. 3101 and wish to express our general support for Senator Bradley's bill, S. 1277, while urging that any waiver of the requirement that States provide optional services on a statewide basis be transitional and time-limited.

With regard to the Medicare Program, we first want to thank the committee for its efforts to put together a draft package which addresses the SNF Medicare access problem, a problem which is growing worse because Medicare beneficiaries increasingly need more acute-oriented SNF services due to the implementation of the hospital DRG prospective payment system, as eight studies cited in our testimony conclude.

We strongly support the committee's proposal not to freeze Medicare SNF reimbursement in fiscal year 1986. AAHA is supportive generally of the proposal to reduce the cost reporting burden for low-volume providers as an incentive to increase provider participation in Medicare.

However, this does not address the most serious element of the access problem. Our members have great difficulty or are unable to admit these sicker patients because the Medicare reimbursement rate is unrelated to the actual cost involved in treating those patients.

The reasons for this gross inaccuracy are, first, Medicare reimbursement rates are based on pre-DRG experience and, second, the cost averaging method effectively uses lower Medicaid costs to calculate rates for the Medicare beneficiaries with more intense care needs.

To address these major causes of Medicare SNF access problems, we strongly urge that the committee consider eliminating the costs of the low-volume providers in calculating cost limits.

In addition, our full statement discusses this in detail, we recommend several other changes, including making minor reforms in the procedures by which homes are granted exceptions to the cost limits.

AAHA strongly supports the retention of the 5-percent threshold on waiver of liability. In Minnesota, the need for retention of the waiver is particularly important as a new Minnesota law requires nursing homes which are Medicaid certified to also be Medicare certified. This means that 241 nursing homes will be new Medicare providers under the Medicare Program with no experience in Medicare coverage decisions.

And if you truly want to increase provider participation, examine the entire area of provider liability, which is ludicrous and punitive in its decisions.

Finally, AAHA supports Senator Heinz' bill, S. 1450, the Home Health Care Preservation Act, as well as an extension of the Medicare Hospice Program.

In conclusion, thank you very much for the opportunity of presenting AAHA's views on these critical Medicaid and Medicare issues.

The CHAIRMAN. Thank you, sir. Dr. Williamson.

[The prepared written statement of Mr. Armitage follows:]

STATEMENT OF ROBERT D. ARMITAGE, EXECUTIVE DIRECTOR, BOARD OF SOCIAL MINISTRY, ST. PAUL, MN, ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

Mr. Chairman and members of the Committee, I am Robert D. Armitage, Executive Director of the Board of Social Ministry in St. Paul, Minnesota. We are a Lutheran multi-facility sponsor, owning and operating seven nonprofit long term care campuses in Minnesota. I am here today representing the American Association of Homes for the Aging (AAHA), a national nonprofit association' which represents more than 2,700 nonrofit providers of long term care, health services, housing, and community services for the elderly.

On behalf of AAHA, I would like to thank the Committee for providing this opportunity to testify on proposals regarding fiscal year 1986 deficit reduction in Medicaid and Medicare.

AAHA is well aware of the need to bring the massive federal deficit under control and recognize that you will be faced with making difficult decisions when the Finance Committee meets to develop its FY 1986 reconciliation package on September 17th. At the same time, we must emphasize that over 22 million of our nation's most vulnerable citizens, the poor and the elderly, depend on the Medicaid program to meet their health and long term care needs and over 31 million elderly and disabled individuals count on the Medicare program to provide coverage for their health care needs. In order to assure access to quality care and services under the Medicaid and Medicare programs, it is essential that it be viable for providers of health and long term care services to participate in these programs.

Within this context, then, AAHA presents its comments on specific Medicaid and Medicare proposals of importance to the elderly and nonprofit providers of long term care services.

MEDICAID

First, AAHA commends the Congress for passing a FY86 Budget Resolution which recognizes the critical importance of the Medicaid program in meeting the health and long-term care needs of this nation's most vulnerable citizens and reflects the fact that Medicaid has already sustained major cuts over the last few years. Congress' decision to reject the Medicaid cap proposed by the Administration in its FY86 budget and, instead, to fund Medicaid at the current services level which allows for an inflation adjustment is a key element of the budget resolution which must be protected during the committee's reconciliation deliberations. To that end, AAHA strongly opposes the Medicaid proposals in S. 1550, the Administration's Health Care Planning and Cost Reduction Amendments of 1985, which include the Medicaid cap and related "flexibility" proposals, such as the elimination of the statewideness requirement for all but mandatory services for mandatory eligibles and the option to establish and/or increase co-payments for many services, which would undoubtedly have a severe adverse impact on Medicaid recipients. As Congress has already clearly rejected the Medicaid cap, we urge that S. 1550 not be part of the Finance Committee's discussion and development of its reconciliation legislation.

In addition, AAHA has the following specific concerns and recommendations about the Medicaid program.

Revaluation of Assets

AAHA has supported the changes in Section 2314 of the 1984 Deficit Reduction Act which limits the revaluation of assets under Medicare and Medicaid when homes change ownership. We are strongly opposed to a repeal or substantial revision of the law as written and urge you not to make any changes in Section 2314 during consideration of reconciliation legislation. AAHA supports the enacted limits on asset revaluation for several reasons:

- The new law helps save federal dollars without adversely affecting the quality of patient care. As the Congressional Budget Office recently estimated, the proposal to permit revaluation up to the Dodge Construction Index for nursing homes under Medicaid would cost $155 million over three years. Unlike reimbursement for other cost centers, additional dollars for capital costs have not resulted in concomitant increases in services. Paying out $155 million for windfall profits to the proprietary nursing home industry makes no sense if one is serious about deficit reduction.
- The old law encouraged rapid turnover of ownership of nursing homes. This "trafficking" problem led to annual turnover in nursing home ownership of up to thirty percent and severely detracted from the stability of the industry to the detriment of patients and the community.
- The old law encouraged further consolidation of ownership in the nursing home industry. In recent years, proprietary nursing home chains have stepped up their acquisitions to such an extent that experts believe the entire industry will be dominated by corporate chains by the end of the decade. The new law will help constrain the proliferation of this oligopolistic trend and will encourage greater diversity and freedom of choice for consumers, while discouraging further corporatization of the industry.

- The old law encouraged real estate speculators to enter into the nursing home industry, rather than people committed to caring for the elderly. Without owner involvement and commitment to the patients, quality of care has suffered. If nursing home ownership has to be a business, it should be a people business, not a real estate business.

It is also important to point out that the new law does not constitute a "freeze" on Medicaid capital reimbursement because payments are permitted to increase for reasons other than a chang in ownership. The new law will not discourage diversification and renovation because it is limited in application solely to sales and mergers, which do not inherently improve conditions for nursing home patients. The new law also is not inhibiting small owners from selling their nursing homes, as evidenced by several recent high-priced transactions. According to a June 1985 article in Today's Nursing Home, "Due to the changes in asset revaluation regulations, many observers speculated that nursing homes would be acquired at reduced costs. But this has not been the case."

AAHA has endorsed the development of a fair rental methodology, which was expressly permitted in the conference report language. This type of system would effectively address the concerns stated above. There is not reason to change the current law to help facilitate implementation of fair rental systems.

Virtually all nursing home reimbursement experts also agree that permitting revaluation of assets upon sale or merger is an unwise policy. For example, a December, 1984 Urban Institute Report entitled "How Should Medicaid Pay for Nursing Home Care?" stated that the traditional capital reimbursement methods "contain a number of undesirable incentives. Most prominent are frequent turnovers, frequent refinancing, and sales-leaseback arrangements which occur to increase reimbursement rates." A March, 1981 report by the National Center for Health Services Research on nursing home reimbursement stated: "cost-related systems have created perverse incentives for nursing home owners (such as trafficking and sale and/or lease-back arrangements) which lead to higher costs to Medicaid without any concomitant increase in the quality of care provided to Medicaid recipients." Finally, an August, 1984 study by the Center for Health Services Research at the University of Colorado Health Sciences Center, entitled "Case Mix and Capital Innovations in Nursing Home Reimbursement" stated: "Historical cost asset valuation stimulates high turnover of ownership (or "trafficking") for nursing homes. Resale usually increases financing debt (the interest in which is reimbursed) and frees the seller's equity in the home (on which a return may not have been paid)... Not only does such resale require the state to pay more for the same physical capital, but some have argued that frequent resale of homes as real estate tax shelters has led to lower quality of care due to the lack of owner involvement and commitment to the industry itself."

Consumer groups for the elderly fully agree with the above assessment, as evidenced by a letter to Senate Finance Committee Chairman Robert Packwood expressing the concerns of American Association of Retired Persons, National Council of Senior Citizens, and National Citizens' Coalition for Nursing Home Reform on this matter. We have attached this letter to our testimony and request that it be included in the record with our testimony. These three organizations stated: "We believe linking the mechanism for setting the value of capital assets to sale provides the wrong incentives for a stable, high-quality health care delivery system", and add "In the current environment of health care cuts and freezes ... it makes little sense to increase payments for capital and cut payments for patient care at the same time."

AAHA believes that we need to encourage long term ownership of nursing homes, not constant churning of real estate. AAHA is grateful that federal cost containment efforts relating to nursing homes have focused on reducing real estate manipulation and limiting windfall corporate profits, rather than on areas which reduce the quality of patient care. Again, we strongly recommend that no changes be made in Section 2314 of the 1984 Deficit Reduction Act.

Boren Amendment

The Boren Amendment, enacted in late 1980 as a part of the Omnibus Reconciliation Act, is extremely important to nursing homes because it is the only standard which prevents states from paying unreasonable and inadequate Medicaid reimbursement rates. AAHA is strongly opposed to changes in the Boren Amendment because such reforms would likely encourage states to reduce their Medicaid payments, which in turn would reduce the quality of care in nursing homes as well as access to care for Medicaid patients. Significant changes in the Boren Amendment could have serious adverse consequences for America's elderly population in need.

HCFA's regulations implementing the Boren Amendment include a provision stating that the average Medicare rate shall constitute the upper payment ceiling for the average state Medicaid reimbursement rate. AAHA does not believe that the Medicare upper limit is appropriate because state and federal budget considerations too often dictate reimbursement rates, rather than actual patient resource needs. For example, if the federal government was to reduce Medicare rates in order to contain costs and control an expanding federal deficit, an upper limit on Medicaid rates would not be fair to states having a budget surplus that could afford to reimburse homes accurately according to patient need. Additionally, application of the Medicare upper limit could inhibit progressive states' efforts to improve access for heavy care Medicaid patients through case-mix reimbursement systems, or to provide appropriate capital reimbursement rates through fair rental value systems. If our goal is to eliminate unnecessarily burdensome regulations and increase states' flexibility in administering their Medicaid programs, as the Boren Amendment was intended to do, then we should eliminate these Medicare upper limit provisions.

Medicaid Home and Community-based Services Waiver Program

AAHA urges you to take action to ease HCFA's overly burdensome requirements on states to participate in the Medicaid Home and Community-based Services Waiver program which are contained in the final regulations for the waiver program published earlier this year. We believe that HCFA's stringent formula to determine the cost-effectiveness of a state's waiver program exceeds Congress' "budget neutral" intent for the program.

As a minimum, we recommend that the Finance Committee include the waiver program provisions in H.R. 3101, as reported out of the House Energy and Commerce Committee on August 1, 1985. These provisions which address problems in the administration of the waiver program, particularly prohibiting the DHHS Secretary from imposing limits on Federal Medicaid matching payments based on a State's estimated expenditures under the waiver and from limiting the average per capita costs of serving clients under the waivers to 75 percent of the average per capita costs of institutional care, are needed to remove an unreasonable penalty on the states which discourages their participation in the program and to help clarify Congressional intent regarding budget neutrality.

AAHA is also very pleased that Senator Bradley has demonstrated his interest and concern about the Medicaid waiver program by introducing S. 1277, the Medicaid Home and Community-Based Services Improvement Act of 1985. AAHA is very supportive of making the waiver program services optional under the state Medicaid plan and encourages the committee to move in this direction.

We are concerned, however, about the waiver of the "statewideness" requirement in the bill. We understand that the current waiver program allows states to target home and community-based services to specific locales and to certain population groups and that this has been the actual practice of the states in implementing their waiver programs. If these services become optional under the state plan, we certainly would not want to discourage states from making the transition from providing these services under waiver authority to offering services as optional ones under their state plans; initially, at least, the general statewideness requirement for providing Medicaid services could act as such a deterrent. However, we believe that any waiver of statewideness that may be deemed necessary initially in order to make this improvement in Medicaid should be considered transitional and be time-limited. In addition, should any waiver of statewideness be granted in this unique circumstance, we would urge that Congress guard against potential future efforts to use this exception as precedent for cutting back on existing covered services under the Medicaid program such as that which has been proposed in S. 1550.

Medicaid Hospice

Finally with regard to the Medicaid program, we recommend that you take this opportunity to make a humane and cost-effective improvement in Medicaid by adding hospice as an optional service under the state plan. As adopted by the House Energy and Commerce Committee, such an action would demonstrate a commitment to provide our nation's poor with a choice about the type of care and setting they need should they be faced with dealing with a terminal illness.

MEDICARE

Skilled Nursing Facility (SNF) Medicare Reimbursement

AAHA is pleased that the Committee has expressed a willingness to address the SNF Medicare access problem by reducing the cost reporting burden for lower volume providers and by not freezing SNF Medicare reimbursement. AAHA also urges the Committee to assist current providers in meeting the acute care needs of sicker patients being discharged from hospitals under DRGs. This is the primary acess problem that one now faces. The data reveal that older Americans have extreme difficulty getting access to SNF Medicare services. SNF Medicare covered days per 1000 elderly beneficiaries declined by over 21 percent between 1976 and 1982, dropping from 413.84 to 324.19 covered days. Since the number of persons over age 65 has risen significantly in that time, with an expected concomitant increase in demand, the reduction in covered SNF Medicare days suggest that availability of these services has declined at an alarming rate. Another shocking statistic reveals that total covered days were reduced by over one-half between 1969 and 1977, dropping from 14.4 to 7.1 million days. Without barriers to access Medicare beneficiaries' covered days surely would have increased.

The shortage of SNF Medicare beds is even more severe in certain parts of the United States. In 1982, 42 states had fewer than ten nursing homes with an average census of at least 16 Medicare patients; 30 states had less than five such Medicare-oriented facilities; while twelve states had no such facilities. In 1980, one-half of the non-metropolitan counties and 17 percent

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of the metropolitan counties lacked any certified skilled nursing facilities. In that year, over half the elderly population in five states (Iowa, Louisiana, Nebraska, New Mexico, and Oklahoma) lived in counties without SNF's; in another eight states more than one quarter of the elderly were in similar circumstances. The proportion of the elderly living in rural areas without SNFs exceeded 50 percent in eleven states and over 80 percent in four states.

These figures reveal only a small part of this dangerously increasing undersupply of needed services. Of major new concern is the skyrocketing demand for SNF Medicare services that has arisen as a result of the new hospital DRG prospective payment system. By providing incentives for hospitals to discharge patients much earlier than before, the DRG system has caused a tremendous increase in beneficiaries' need for post-hospital rehabilitative SNF Medicare services. DRGs are working, as length of stay in hospitals has declined from 9.5 days to 7.4 days in the past year. Numerous studies have documented the greater pressure nursing homes are now under to admit Medicare beneficiaries discharged from hospitals.

The National Center for Health Services Research found, "About 70 percent of 99 charges to nursing homes stayed beyond the average for their DRGs compared to only 48 percent patients with a regular discharge period. Elderly Medicare patients needing long term care services would account for about nine days of unreimbursed care per discharge compared to three days for a patient discharged to self care." The report documents that many patients discharged to nursing homes required a longer than average stay in the hospital and, therefore, would have been financial "losers" for the hospital. Clearly, such patients are much more likely to be discharged prematurely.

A report released on February 21, 1985 by the U.S. General Accounting Office at the request of the Senate Special Committee on Aging found that "patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health" than before DRGs were in place. The report also noted that, with some exceptions, nursing home beds for early hospital discharge are not readily available. The study concludes, "We believe that the issues discussed in this report are sufficiently important to warrant HHS studies that will assess problems in access to and quality of post-hospital services supported by Medicare."

Surveys conducted by the House Select Committee on Aging and the National Association of Area Agencies on Aging found that patients are leaving hospitals sicker and are requiring more post-hospital care since the enactment of the DRG system. Respondents to the House Committee survey, long term care ombudsmen in all 50 states, indicated by an overwhelming margin of 77 percent that patients have been leaving hospitals in a sicker condition since the enactment of the DRG payment system.

Two studies conducted this year in Illinois also found that nursing homes are being asked to care for sicker patients. Of the 73 homes responding to a questionnaire distributed by Alden Management Services, Inc., in the Chicago metropolitan area and rural Illinois areas, 89% reported that, since the implementation of DRGs, residents transferred from hospitals to long term facilities required a higher level of skilled nursing care than previously. The other Illinois study found that well over three-quarters of the hospitals polled experienced difficulties in discharging sub-acute care patients, due to limited placement options. In 3 out of 4 cases, the sub-acute care needs were too heavy for a placement to be found. The report concludes, "Patients are more severely ill . . . when leaving the hospital, SNFs are unable to care for them and are rehospitalizing them in greater numbers."

A recent inspection by the Office of the Inspector General also found a "serious problem encountered during our ongoing review of the implementation of the prospective payment system." The October 23, 1984 OIG memorandum to HCFA Administrator Carolyne Davis stated: "We find that evidence is mounting to suggest abuse of the pps is occurring through the premature discharge and subsequent readmission of patients in need of in-patient care," and added, "As of July 1, 1984, 1,130 of these cases have been identified by MREs across the country. Additionally, our analysis of data from health standards and quality bureau regional offices and MREs indicates that the actual number of cases may be significantly greater."

Finally, AAHA, together with the American Health Care Association (AHCA) conducted a survey of over 1000 Medicare certified nursing homes. 172 facilites responded, totaling 22,359 beds, of which 13,476 were Medicare certified. 56.4% reported an increase in the demand for SNF services as a result of hospital DRGs (75% of the facilities with ten or more Medicare patients reported such an increase). Two-thirds reported an increase in the intensity of Medicare SNF services needed as a result of hospital DRGs (85% of facilities with tem or more Medicare patients reported such an increase). We have attached a summary of this survey's findings.

AAHA is grateful for the Committee's proposal to reduce the cost reporting burden for low volume providers to encourage greater participation by those not involved or only marginally involved in the system. The studies cited above, however, reveal just how difficult it is for current providers to meet the more acute care needs of the Medicare patient population in SNFs while retaining their current volume at present levels. Unless something is done to assist SNFs in caring for these heavier care patients, serious access problems will persist and federal expenditures will increase as these patients get backed up in hospitals or go to more expensive settings.

We are very pleased that the Committee is considering not freezing reimbursement to Medicare SNF providers. As our survey indicated, if such a freeze took place, 13% of respondents would drop out of the program and total Medicare admissions would be reduced by almost 22%. However, this alone will not prevent the access problem from growing worse. HCFA reported that last year 35 percent of all SNFs were at or over the cost limits, while approximately two-thirds of the homes in the six states with relatively more participants were exceeding the limits. These figures are undoubtedly higher this year with more hospitals involved in and adjusting to DRGs. It is also very important to note that the data used to calculate SNF Medicare cost limits is based on pre-DRG experience. While the cost limits may be adjusted for inflation, no adjustments have ever been made to account for the more intensive care needs patients are now having after discharge from the hospital. Without question, the current cost limits do not reflect what is actually happening in nursing homes because they fail to account for the impact of DRGs.

There is a second reason why the SNF cost limits are artificially low and do not reflect actual experience. The current system is essentially an averaging process of per diem costs of each provider's overall patient population, including residents covered under the Medicaid program. Since Medicare and Medicaid SNF patients typically are cared for by similar staff in the same general location of the nursing home, an accounting artifact was designed which averages together the cost for treating both Medicare and Medicaid patients in reimbursing for Medicare patients only. Since it is very difficult to isolate the costs of caring for Medicare versus Medicaid patients in this setting, the lower cost for treating Medicaid patients is included in calculated Medicare rates, thereby artificially reducing SNF Medicare payments. Thus, Medicaid costs are being used to calculate Medicare rates. This cost averaging methodology means that the calculation of the SNF cost limits does not reflect the actual cost in caring for Medicare patients. Particularly in the large majority of facilities that have a greater number of Medicaid patients than Medicare patients, the SNF Medicare rate better reflects the costs in caring for Medicaid patients, not the more expensive, heavier care Medicare patient. Such a system is grossly unfair and is a major factor contributing to the SNF Medicare access problem.

While it is difficult to create a new accounting method to overcome the problems with the cost averaging process, something must be done to improve the system so that the Medicare rates accurately reflect the treatment of Medicare patients, rather than Medicaid patients with less intensive care needs. The costs of homes with many Medicaid patients and few Medicare patients should not be included in the calculation of the mean for the purposes of the cost limits because they are unfairly penalizing other homes. Cost averaging should cause us to look to those homes with relatively greater Medicare participation because their experience more accurately reflects the actual costs in treating Medicare patients. Costs in homes below a certain threshold of Medicare participation should not be included in the calculation of the cost limits. If we eliminate those homes with less than 1000 Medicare days or 5 percent Medicare days, rates will more precisely reflect Medicare experience. Such an adjustment should not be permitted for hospital-based facilities, because they are already getting paid 50 percent more than free-standing facilities.

The best way to address the SNF Medicare access problem is to have a rate structure which reflects the actual costs of caring for Medicare patients. Currently, the system takes no account for sicker patients being discharged by hospitals and, to some degree, is paying Medicaid rates for the treatment of Medicare patients. These inaccuracies must be addressed if we are to have a fair system for treating post-hospital Medicare patients.

The SNF Medicare cost limits also operate to unfairly restrain homes because of the questionable methods used for granting exceptions to the limits. The first problem is that the process is exceedingly lengthy. Homes must wait up to three or four years before receiving relief. The cash flow problems faced during that time can be detrimental to the facility's financial well-being. The time taken in considering exception requests must be reduced. Second, the use of numerous different peer groups for comparative purposes has caused inconsistent and arbitrary results. In one specific instance, HCFA used four different peer groups in determining a request, making it virtually impossible to determine with any precision if the facility had atypical costs. A uniform definition for peer groups must be created so that these inconsistencies will not continue. The homes whose mean costs are used in calculating cost limits should be those used as peer groups. Finally, homes do not have information on comparisons made in specific cost centers. Again, this absence of information makes it virtually impossible to show atypical costs in a particular cost center. Homes must have access to these benchmarks if they are to meet their burden of proof. Each of these three recommendations is an important step in making the exceptions process fairer. The proposals have no cost implications and constitute relatively minor changes in the system. We have drafted proposed language on these issues and urge the Committee to consider these recommendations.

We also hope the Committee will take a closer look at two serious problems. First, the three day prior hospitalization requirement for admission to a skilled nursing facility under Medicare has, in several cases, operated to deny access to those deserving care. Specifically, cancer patients and those who undergo surgery in an outpatient setting often are unfairly denied SNF Medicare coverage. We urge the Committee to look at these specific instances in which an exception from the hospitalization requirement should be granted. Second, we are concerned about the rapid proliferation of hospital rehabilitation units which are exempt from the prospective payment system. HCFA data indicates that these rehabilitation units, in the aggregate, serve patients similar to SNF Medicare facilities. However, while nursing homes are paid approximately $60 for treating these patients, rehabilitation often receive $300 - $400. We urge the Committee to investigate what we perceive as an unnecessarily costly trend, and an extremely unfair method of payment. Ideally, a system which accounts for the intensity of rehabilitation needs should be in place for all providers of rehabilitative care, with a rate structure based on patient resource use, rather than on the location of the patient's treatment. Addressing this problem could save significant federal dollars by reducing unnecessary expenditures on unconstrained hospital rehabilitation costs.

AAHA feels strongly that the SNF Medicare access problem can be best addressed by enabling providers to admit and care for the sicker Medicare patients now being discharged from the hospital. Since it is not possible to base payment rates on post-DRG experience or to change the cost averaging accounting system, we need to exclude the lowest volume providers from the calculation of the mean for cost limit purposes, and improve the procedures by which exceptions to the limits can be attained. Without such reforms, the proposals the Committee is considering will have limited success in improving access to needed services for older Americans.

SNF Medicare Coverage Issues

AAHA is very pleased that the Committee is considering improvements in the administration of SNF Medicare coverage by keeping the 5% threshold of the waiver of liability and by reducing inconsistency through fewer intermediaries with uniform training. We believe the retention of the waiver of liability be of utmost importance.

On March 14, 1985, the Administration proposed eliminating the waiver of liability, a provision which has afforded nursing homes and other providers a cushion for coverage denials made in eligibility determinations. Under the statutory provision, the waiver provides relief to a beneficiary or provider who acted in "good faith" in accepting and providing services, later found by the intermediary to be not reasonable or necessary. Making these determinations is often impossible because the grey areas are larger than the black and white. For providers to be held liable for their "good faith" effort is simply ludicrous. Having the waiver has enable many providers to remain in a program that has few, if any, incentives to be in it in the first place.

Without question, the group that would be most severely hurt by the issuance of the rule as proposed are Medicare beneficiaries. The proposed change would drastically reduce Medicare beneficiaries' access to skilled nursing facility (SNF) and home health agency (HHA) Medicare services, and would also force these consumers to incur out-of-pocket costs in order to receive services that should be covered by the Medicare program. These adverse consequences will result because the proposals would provide strong incentives for SNFs and HHAs to drop out of the Medicare program completely, severely reduce post-hospital admissions to those lacking substantial private resources, and/or require private payments from beneficiaries for all but the most obviously covered Medicare services.

The real problem, of course, lies in the fact that fiscal intermediary (FI) coverage decisions under the SNF Medicare benefit are grossly inconsistent, imprecise, and biased. This problem has been well documented in a study published in the New England Journal of Medicine exploring how different intermediaries interpreted Medicare SNF coverage for nine hypothetical cases. The authors concluded:

> Medicare coverage for skilled nursing care is not aclear cut, predictable benefit from either the physicians or the beneficiaries point of view. Instead, it is highly unpredictable and dependent on criteria that are often implicit, unwritten, and not available for perusal or comment. Differences in criteria and the application of rules of thumb must inevitably lead to disagreement not only on coverage but on the reasoning behind the reward or denial.

The 22.5 percent SNF and 32.4 percent HHA reconsideration reversal rates further support the contention that there are serious problems in coverage determinations and that the proposed rule would only exacerbate these problems. We believe that if providers and beneficiaries had the assistance of legal counsel experienced in this area, the reconsideration reversal rates for SNFs would be much higher. This conclusion is based on the experience of the Connecticut Legal Assistance to Medicare Patients project (LAMP) which has been successful in 80 percent of their requests for reconsideration. Rather than attempting to resolve this problem of arbitrary and inconsistent coverage decisions for SNF and HHA services, this rule, in effect, proposes instead to make the process more unfair by encouraging providers to avoid financial punishment for coverage denials by shifting the costs onto the shoulders of beneficiaries.

The SNF coverage situation is growing rapidly worse, as our survey, discussed above, found 43% of the respondents reporting that their intermediary coverage decisions had grown stricter within the last year. We asked these providers what actions they would take if the waiver were eliminated altogether; 16.5% said they would drop out of the program completely. Respondents also reported they would reduce Medicare admissions by an average 26.2% and decrease days submitted for coverage by 28.1%.

It is extremely important that the 5 percent threshold to the waiver of liability presumption be maintained. If this is eliminated or reduced, only the most obvious cases will be submitted for coverage, and access problems will grow worse. If we are concerned about increasing participation by low volume providers, the 5 percent threshold takes on even greater importance because of the low number of total days in the denominator and relatively little experience these homes have with making coverage determinations. The waiver of liability is critical to providers' continued participation in the SNF Medicare program.

It is our understanding that the Committee is considering a proposal to reduce the number of FIs to ten for purposes of Medicare coverage determinations.

This reform alone will not address the problem of inconsistent determinations unless the FIs are chosen carefully, are held accountable for their performance, and receive uniform training. In this regard, we have enclosed a statement by a coalition concerned with SNF Medicare coverage and request that it be submitted for the record. It is critical that regional intermediaries not be selected according to how much money they can save by increased denials, but instead, according to their experience with SNF Medicare coverage, promptness in processing the claims and reconsideration requests, cooperation with SNFs, and accurate application of SNF coverage guidelines (possibly measured by the frequency of subsequent reversal). Transition costs should also be passed through. AAHA also recommends that an exceptions process be included under which large facilities with many years of working with the same intermediary can choose to continue their relationship. We also feel that hospital-based facilities should be included under the ten regional intermediary plan. Overall, it is of utmost importance that information on intermediaries' performance be available in the form of publication of performance statistics, together with the facts and rationale for cases that are not clearly covered or uncovered.

The process by which intermediary coverage decisions are appealed is also in dire need of reform. The first option available to beneficiaries is reconsideration by the same FI. Not only does this rarely occur, but FIs rarely overturn their own decisions. The next step is an appeal to an administrative law judge (ALJ). A miniscule .3 percent of cases reach this stage. This is an astonishing statistic, particularly when one considers that attorneys in Connecticut have an 80 percent success rate at this level. The primary problem is that beneficiaries do not know of their right to appeal and very often cannot afford an attorney to bring the case. We recommend that attorneys' fees be available under the Equal Access to Justice Act for cases appealed to the ALJ level and beyond. In the alternative, we strongly urge the Committee to adopt the proposal by the House Committe on Energy and Commerce which permits providers to represent beneficiaries for such appeals. Another problem that exists is similar to the one experienced by SSI recipients on disability cases. Specifically, ALJs follow a policy of non-acquiesence and ignore decisions by district and circuit courts. A determination by one of these courts has absolutely no precedential value for subsequent decisions made by FIs or ALJs. This situation is grossly unfair and must not continue. We urge this Committee to take a close look at these and other problems with the procedures by which beneficiaries can appeal SNF Medicare coverage determinations.

Again, we thank the Committee for taking a serious look at SNF Medicare coverage problems. Your proposals, particularly retaining the waiver of liability and not freezing reimbursement to Medicare SNF providers, will have a very positive effect on both providers and beneficiaries. We urge that in moving ahead you consider our comments and continue your efforts to provide access to needed post-hospital Medicare-covered care and services for our nation's elderly.

Medicare Home Health

AAHA urges you to incorporate S. 1450, the Home Health Care Preservation Act, in the Finance Committee's reconciliation legislation. Introduced by Senator Heinz (R-PA) and co-sponsored by four other Finance Committee members -- Senators Durenberger (R-MN), Moynihan (D-NY), Bradley (D-NJ), and Mitchell (D-ME), this legislation would delay implementation of HCFA's July 5th Medicare home health cost limit regulations which serve to reduce reimbursement to home health providers at a time when home health care is increasingly needed by Medicare beneficiaries being discharged from hospitals more quickly and in a sicker condition due to the hospital DRG payment system.

The regulations restructure the cost limits by setting the limit at 120% of the mean labor-related and nonlabor per visit costs in 1985 (115% of the mean in 1986 and 112% of the mean in 1987) instead of the formerly used 75th percentile and by applying the cost limits to each discipline separately (e.g., skilled nursing and physical therapy) rather than to the agency's aggregate costs. By HCFA's own estimates, these changes will adversely affect 70% of home health care providers participating in Medicare. Based on this estimate, AAHA is convinced that these regulations are overly harsh in clamping down on home health reimbursement and far exceed HCFA's stated goal of creating incentives for improved provider efficiency.

As expressed in comments to HCFA when the regulation was proposed, AAHA has several serious concerns about the changes including:

- The outdated nature of the cost data utilized to calculate the cost limits: These data -- from Medicare cost reports ending on or before September 30, 1983 -- completely pre-date the October 1, 1983 implementation date for the phase-in of the Medicare hospital DRG payment system which is having an impact on post-hospital care such as home health. The home health cost limits based on pre-DRG data, however, totally ignore these more recent home health agency (HHA) costs associated with serving increasing numbers of these post-DRG patients with their more intensive service needs. By itself, this exclusion of the escalating intensity factor from these data used to compute the cost limits serves to constrain reimbursement to HHAs facing the challenge of serving a sicker patient population. AAHA strongly believes that ignoring this significant reality, while also further tightening the cost limits by moving to 120 percent of the mean and below and applying the limits to each discipline separately, will threaten HHAs' ability to provide the necessary level of quality services to Medicare beneficiaries regardless of how efficient the agency may be.

- Setting the limits at 120 percent of the mean labor-related and nonlabor per visit costs in 1985: This concern only increases with HCFA's intention to reduce further the limits in 1986 and 1987 by moving to 115 percent and 112 percent of the mean cost respectively. First, while it may make sense to move toward consistent reimbursement methods for HHAs and SNFs under Medicare, it definitely makes sense that, before such action is taken, HCFA carefully evaluate the success or failure of that "consistent" reimbursement methodology currently applied to SNFs. As HCFA knows, experience with the Medicare SNF benefit has been riddled with problems, particularly related to provider participation in the program. Probably the primary factor explaining SNF providers' lack of participation is the inadequacy of reimbursement. With 35 percent of the nation's Medicare SNFs reaching the cost limits last year, and approximately two-thirds of the high volume providers being constrained by the limits, we must question the wisdom of seeking to duplicate this cost limit methodology on another provider group. Applying a reimbursement methodology to HHAs that has been a failure for SNFs is not sound policy and would do a disservice to both HHAs and the elderly who increasingly need their services.

- Applying the cost limits to each discipline separately (i.e., skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide): We believe that separate application of the cost limits will destroy HHAs' ability to provide care and services from the total patient care approach. This approach is essential, as the value of the home health benefit for Medicare beneficiaries comes from receiving the needed mix of service disciplines which, in the aggregate, best effectuate rehabilitation and recovery. The current aggregate application of the cost limits makes it possible for HHAs to provide all six service disciplines, even if some of the services are needed by only a small number of their patient caseload. Moving to separate application of the cost limits will create a strong incentive for HHAs to discontinue providing those lower volume/higher cost service disciplines -- services which may not be needed by many but are critically needed for the successful recovery of a few Medicare beneficiaries.

Moreover, AAHA joins Senators Durenberger and Heinz in their view that HCFA exceeded its authority in publishing the proposed notice. As Senator Durenberger's May 23, 1985 letter to DHHS Secretary Heckler states, ". . . major policy changes in the Medicare program are the responsibility of the Congress . . . Recent proposed regulations concerning Medicare home health cost limits . . . cross this fine line between policy implementation and policy making."

AAHA believes that HCFA's July 5th home health cost limits regulations constitutes a very serious budget cutting initiative which will likely force HHA providers to cut back on services, limit access to services and/or drop out of the Medicare program entirely. These regulations run counter to the need to meet better the increasingly visible and intensifying home health care needs of Medicare beneficiaries. Again, we urge you to adopt S. 1450 as part of the committee's reconciliation package.

Additionally, the increasing need for post-hospital care and services created by implementation of the hospital DRG payment system (as discussed in detail earlier in relation to the Medicare SNF benefit) applies to home health care services as well. Therefore, AAHA strongly recommends that no FY86 reimbursement freeze for Medicare home health providers be adopted and we reiterate the need to retain the waiver of liability for home health agencies, as well as for skilled nursing facilities.

Medicare Hospice

AAHA supports repeal of the 1986 sunset date for the Medicare hospice benefit and asks you to include an extension of the hospice benefit in the Finance Commitee's reconciliation package. Hospice is a sensitive approach to caring for the terminally ill and should remain an option for Medicare beneficiaries who are faced with making the many difficult decisions that a terminal illness requires.

In addition, in order for hospice to be a realistic option for Medicare beneficiaries, they must have access to Medicare hospice services in their communities. As you know, hospice reimbursement under the Medicare program has been problemmatic from the outset. Inadequate reimbursement rates have served to keep provider participation in the program low and thus, have limited beneficiary access to these services. To address this continuing problem, we recommend that you take action to increase the daily payment rates by $10 each per day, as reported out of the House Ways and Means Committee in H.R. 3128.

CONCLUSION

While you, as members of the Senate Finance Committee, are confronted with the difficult task of achieving FY86 deficit reduction savings in Medicare and Medicaid, you also have the opportunity to make improvements which are cost-effective and which will help to increase beneficiary access to services in these critical health and long term care programs. We urge you to consider our recommendations and again, thank you for the opportunity to present AAHA's views on key Medicaid and Medicare issues.

STATEMENT OF DOUGLAS E. WILLIAMSON, M.D., PRESIDENT, OUTPATIENT OPHTHALMIC SURGERY SOCIETY, VENICE, FL; ON BEHALF OF THE SOCIETY FOR OFFICE BASED SURGERY

Dr. WILLIAMSON. Mr. Chairman, I am Dr. Douglas Williamson of Venice, FL.

In 1970, 15 years ago, I opened the first surgery facility in the United States that was specifically designed for outpatient ophthalmic surgery.

I appear before you today as president of the Outpatient Ophthalmic Surgery Society. These views are also supported by the Society for Office Based Surgery, the freestanding ambulatory surgical association, and the American Intraocular Implant Society, organizations dedicated to the conduct of safe, effective, medically appropriate and cost-efficient surgery in the outpatient surgical setting.

Mr. Chairman, I would like to address legislation which embodies great potential to significantly reduce Federal expenditures for ambulatory surgery, particularly cataract surgery.

I am speaking of the need to ameliorate the gross disparity in Medicare facility reimbursement to ambulatory surgical centers and hospital outpatient departments and the need to improve incentives for the establishment of high quality, lower cost Medicare-certified ambulatory surgical centers.

The aforementioned organizations are united in support of S. 1489, the Medicare outpatient surgery savings acts as a quality act, introduced by Senator Durenberger, because we believe that this legislation will accomplish these objectives.

We are pleased that the major components of the legislation have been included in the chairman's budget reconciliation package, and we recommend favorable committee action on these amendments.

There are a number of factors which affect the development of freestanding ambulatory surgical facilities: economics, quality of care, and governmental pressures like PRO's.

The greatest boon to the establishment of these facilities was the Medicare ambulatory surgical center program, implemented in September 1982. A Medicare certified ambulatory surgical center receives a flat prospectively determined facility fee for each of the 100 or so procedures which have been approved by Medicare.

The facility fee ranges from $231 to $504, the latter of which happens to be the payment for a cataract extraction and intraocular lens implantation. The total cost of the cataract is as follows: to the Government, $504, plus the cost of the intraocular lens; to the beneficiary, the patient, no cost.

Now, contrast the cost to the Government for the same procedure in a hospital outpatient department. The Medicare prospective payment system does not apply to the hospital outpatient department. Medicare continues to pay the hospital outpatient department 80 percent of its costs and charges.

Our society, the Outpatient Ophthalmic Surgery Society, has collected data from hundreds of hospitals in over 20 States and discovered that hospital charges for cataract surgery typically exceed $2,000.

The CHAIRMAN. That hospital what?

Dr. WILLIAMSON. Hospital charges for cataract surgery typically exceed $2,000. The inspector general has determined that the Government is paying between $1,250 and $2,796 to the hospital outpatient department for this service, compared to $504, plus the intraocular lens in the ambulatory surgical center.

Charges for surgery performed in the hospital outpatient departments always substantially exceed the amounts paid to ambulatory surgical centers. Indeed, hospital outpatient reimbursement often exceeds the inpatient DRG payment, despite the fact that the patient is discharged within a matter of hours and the hospital incurs no bed import costs.

Both the HHS inspector general and the Budget Office have concluded that Medicare can save hundreds of millions of Medicare dollars per year by paying hospital outpatient departments and freestanding ambulatory surgical centers comparable amounts.

This is exactly what Senator Durenberger's legislation would accomplish. It would level the playing field between facility payments to hospitals and freestanding ambulatory surgical facilities.

This approach is an equitable one which will promote the fair competition and conserve scarce health care dollars. And more important, these savings could be realized without reducing benefits or compromising the quality of care.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared written statement of Dr. Williamson follows:]

STATEMENT OF DOUGLAS WILLIAMSON, M.D., PRESIDENT, OUTPATIENT OPHTHALMIC SUGERY SOCIETY, SUPPORTED BY THE SOCIETY FOR OFFICE BASED SURGERY, THE FREESTANDING AMBULATORY SURGERY ASSOCIATION

I am Dr. Douglas Williamson of Venice, Florida. Fifteen years ago, I opened the first surgery facility in the United States that was specifically designed for outpatient ophthalmic surgery. I appear before you today representing several organizations which are dedicated to the conduct of safe, medically appropriate, and cost-efficient surgery in the various ambulatory surgical environments. This testimony is presented on behalf of the following organizations:

- The Outpatient Ophthalmic Surgery Society, of which I serve as President, a professional medical specialty organization of over 900 ophthalmologists.
- The Society for Office Based Surgery, a professional medical organization comprised of over 500 specialists in gynecology, urology, otolaryngology, ophthalmology, anesthesiology, orthopedics, and plastic, hand, colon-rectal, oral and general surgery.

and is furthermore supported by:

- The Freestanding Ambulatory Surgery Association, a national organization of over 130 freestanding ambulatory surgical centers.

Mr. Chairman, these organizations are united in support of S.1489, "The Medicare Outpatient Surgery Savings Access and Quality Act," introduced last month by Senator David Durenberger. We would hope that this legislation will be included in the budget reconciliation package which will be developed by the Senate Finance Committee in the days ahead. We share the goal of this Committee and Congress of ensuring that Medicare beneficiaries receive the highest quality care at the lowest possible cost. We are enthusiastic about Senator Durenberger's bill because we believe that it truly strikes an appropriate balance between these sometimes conflicting objectives.

As our data, the HHS Inspector General's audit, and the Congressional Budget Office estimates indicate, the concept of "leveling the playing field" in ambulatory surgery facility reimbursement embodie in this legislation will significantly impact upon Medicare expenditures for cataract surgery, a major concern since Medicare is footing virtually the entire national cataract bill, a bill which is increasing annually as patients demand a procedure which results in rapid visual restoration without significant discomfort. Even greater savings accrue if Senator Durenberger's methodology is applied to all surgical procedures which can be safely and effectively performed in freestanding ambulatory surgical centers as well as hospital outpatient departments.

We believe that an important response to the question of skyrocketing health care costs is to promote the utilization of freestanding ambulatory surgical facilities. There are a number of factors fueling the development of freestanding ambulatory surgical facilities -- economics, quality of care, and governmental pressures.

With regard to economics, quite simply, ambulatory surgery costs one-third to one-half as much as surgery conducted within the hospital environment -- both on an inpatient and outpatient basis. Insurance carriers and employers throughout the country have recognized the potential for health cost savings by providing reimbursement incentives to physicians and patients to promote the performance of surgery within the freestanding environments.

Ambulatory surgical facilities also offer the opportunity for the provision of high quality surgical care. Medicare conditions of participation, state licensure, and private peer-based accreditation efforts by such organizations as the Accreditation Association for Ambulatory Health Care assure a quality of care that is at least comparable to, the hospital setting. Procedures conducted within ASCs are limited to those which can be safely and effectively performed within the ambulatory environment. The patient is able to more quickly resume normal activities with less disruption of family life. Moreover, the patient is having his surgery conducted without the exposure to contagious disease and infection incident to hospital care. Surgical care in the freestanding ambulatory facility also minimizes the anxiety which elderly patients experience with regard to hospitalization and surgery; studies suggest that freestanding units outperform hospitals in friendliness of staff, attention to a patient's needs, and pleasantness of environment.

Moreover, surgical, preoperative, and postoperative care attain optimum levels since the surgeon has access to specialized equipment and employees who are specifically trained in ambulatory surgical care. From the standpoint of the physician's efficiency, he is able to schedule a greater number of medically appropriate procedures, since he is performing surgery in an environment free of being "bumped" from the surgical schedule and free of the significant turn-over time between operations in the hospital various outpatient department.

Governmental pressures have also intensified the migration of surgical services from the hospital inpatient to outpatient arenas. The Medicare prospective payment system has ratcheted down inpatient reimbursement, and private carriers are following suit. Peer review organizations have contracted with HCFA to reduce admissions in certain high-utilization DRG categories; indeed, thirty five states' PROs have applied some form of limitation on the conduct of cataract surgery on a hospital inpatient basis. It now appears that Congress may, rightfully, place limits on hospital outpatient reimbursement as well.

Perhaps the greatest boon to the conduct of surgery in the freestanding surgical environment is the Medicare ambulatory surgical center program, implemented in September, 1982. A facility which is certified for Medicare reimbursement receives two basic benefits. The facility receives a facility fee for each of the 100 or so surgical procedures approved by the Medicare program; this facility fee ranges from $231 to $504, the latter being the reimbursement rate for a cataract extraction and intraocular lens implantation. Moreover, the surgeon who conducts a Medicare-approved procedure in a Medicare-certified ASC and who accepts Medicare assignment receives 100%, rather than 80%, of his reasonable charge. Under these circumstances, the patient is not liable for any coinsurance amounts with respect to the facility fee or the surgeon's charge. In other words, under the Medicare ASC program, the elderly beneficiary, who may likely be living on a fixed income, can have his surgery conducted and incur no out-of-pocket expense. As an example, the total cost of the cataract procedure is as follows: to the government, $504, plus the cost of the IOL; to the beneficiary, no cost (if the physician accepts assignment.)

Let us contrast these levels with the reimbursement amounts paid to hospitals.

On an inpatient basis, hospitals are reimbursed for their facility costs incident to cataract surgery at a rate of approximately $1,300 to $1,500 under DRG #39. However, as noted above, the activities of peer review organizations and changes in technology and surgical technique have led to a substantial migration of services away from the hospital inpatient operating room.

It is estimated that approximately 70% of the over 800,000 cataract procedures performed this year will be conducted in hospital outpatient departments. The Medicare prospective payment system does not apply to the hospital outpatient setting. Medicare continues to pay on the basis of 80% of the lower of reasonable costs or charges, with the patient responsible for the difference in the form of 20% coinsurance. One would expect that, since there is no room and board component to the same-day procedure, hospital charges for cataract surgery on an outpatient basis would range between the freestanding ASC rate of $504 (plus IOL) and the inpatient DRG rate of about $1,400.

However, charge data which we have collected throughout the country, and information isolated by the HHS' Inspector General demonstrate that charges for the facility component of cataract cases performed in hospital outpatient departments often substantially exceed the amounts paid to ASCs, and, indeed, often exceed the inpatient DRG payment.

Our survey of over 200 hospitals in twenty states showed that hospital outpatient charges for cataract surgery range from just under $1,000 to over $4,000, with an apparent average of about $2,000. If we assume some reasonable correlation between hospital outpatient department charges and reimbursable costs, it is apparent that hospital outpatient departments are being reimbursed for their facility costs at rates which are significantly higher than the rates paid to ambulatory surgical centers, and, in some instances, even higher than rates paid for services rendered to hospital inpatients under DRG #39.

In some areas where ASCs have been established, hospitals have aggressively marketed their services by advertising that they will waive the 20% coinsurance for Medicare beneficiaries. It is no wonder that a hospital can afford to waive the patient's coinsurance when it is receiving facility reimbursement amounting to two, three, or four times higher than the reimbursement to the freestanding ASC in the community.

These discrepancies in reimbursement lead us to conclude that Medicare is paying hospitals, on the average, hundreds of dollars more for cataract procedures as well as other surgical procedures, in the hospital outpatient department than in the ASC. In times of fiscal austerity, when the government should be promoting fair and healthy competition among providers, the reimbursement differentials for cataract surgery and other surgical procedures simply cannot be justified.

There is an alternative, and we would urge this Committee to adopt as part of its budget reconciliation package the provisions of S.1489 which would rectify this reimbursement anomaly and provide other incentives for the establishment of ambulatory surgical centers, where this nation's citizens can receive the highest quality surgical care at reduced cost.

- The legislation approved by the Committee should "level the playing field" between facility payments made to hospitals and freestanding ambulatory surgical facilities for all ambulatory surgical procedures. It should establish a prospective payment mechanism for surgery performed in hospital outpatient departments. Under S.1489, Medicare would not pay for any procedure performed in a hospital outpatient surgical facility an amount more than the DRG rate for the same procedure. In addition, under Senator Durenberger's bill, for procedures on the ASC procedures list, Medicare would pay the hospital outpatient department an amount equal to the ASC facility rate for that procedure. This approach is an equitable one which will promote fair competition and conserve scarce health dollars. The Inspector General has estimated that if this reimbursement methodology were applied to cataract surgery alone, the federal government would save $325 million per year. It is our understanding that the Congressional Budget Office has determined that the application of this methodology to all procedures which can be performed in ASC would result in over $1 billion in budgetary savings over three years. These savings are phenomenol and can be realized without reducing benefits or compromising quality of care.

- The legislation adopted by the Committee should incorporate provisions of S.1489 which require the Health Care Financing Administration to update the facility rates paid to ambulatory surgical centers prior to January 1, 1986, and to adjust these rates at least annually. Should HCFA be unable to complete its cost survey and develop new rates prior to January 1, 1986, the agency should be directed to apply whatever rules are ultimately established retroactive to January 1, 1985. ASC facility payment rates have not been increased since the ASC program was initiated in 1982. The payment rate for a procedure like cataract extraction, i.e. $504 plus IOL, is probably $100 to $300 lower than the actual costs incurred in conducting the procedure. (It is for this reason that many multi-specialty ASCs cannot afford to offer cataract surgery services.) For well over two years, HCFA has been promising the ambulatory surgery community that it will conduct a survey of Medicare-participating ASCs to ascertain appropriate facility rates for of covered procedures. As recently as last month, HCFA indicated that payment rate adjustments will not likely be effective for at least 12 months. The failure of Medicare to update these rates is clearly stifling the development and expansion of ASCs which have proven that they can deliver a broad array of surgical services at significantly lower cost than other providers.

- The legislation adopted by the Committee should incorporate provisions of S.1489 which require the Health Care Financing Administration to update on an annual basis the list of surgical procedures for which ASC facility reimbursement may be provided. The current list has not been expanded since the ASC program was initiated in 1983.

- The legislation adopted by the Committee should incorporate provisions of S.1489 which modify the methodology used to determine the amount of facility rates paid to ASCs and hospitals by providing that such rates are to include all Medicare-covered services except physicians' services. Under this provision, for example, intraocular lenses and other prosthetic devices provided to surgical patients would not be reimbursed separately under Part B of the Medicare program, but would be paid for as part of an expanded prospectively determined facility rate.

- We would not object to the provision of S.1489 which mandates PRO review of procedures conducted in hospital outpatient departments and ASCs, provided that HCFA specifically requires PROs to establish criteria for review of these procedures and that thecriteria are developed "in the sunshine" in consultation with interested local and national medical organizations. The history so far of PRO review of hospital inpatient cataract surgery suggests that many PROs do not yet adequately perform those review functions. HCFA has negotiated "targets" for reduction of procedures with each PRO which are often treated as "quotas" for the procedures. Some PROs have no criteria; many have arbitrary criteria. We strongly support PRO review of hospital outpatient and ASC procedures; but that review should occur only after PROs have demonstrated fairness and proficiency in effecting the review.

The aforementioned organizations appreciate the opportunity of appearing before this distinguished body to discuss these issues of vital concern to the health care community. In the interest of promoting fair competition among providers and reducing health costs to beneficiaries and the Medicare program, we look forward to working with the Committee in equalizing facility reimbursement rates for surgery performed in the various surgical environments.

The CHAIRMAN. Mr. Bromberg, your testimony suggests the development of a prospective payment system for hospital capital and return on equity. Give me a rough idea of how you think this would work.

Mr. BROMBERG. There are several options, and eventually the Department will hopefully get you all of them, with the one they recommend; but in the meantime, Senator Durenberger has introduced a bill which over a 6-year period would phase in to a national rate for capital, exactly as we now do with operating costs.

In other words, over the 6-year period, a hospital will get a certain percentage of its own individual capital costs and a certain percentage of a national add-on or rate. For example, something in the neighborhood of a 7 or 7½ percent add-on.

The amount of that add-on obviously will be the bone of contention because OMB, on the one hand, will want to keep it low, and we are concerned that, as we hold down hospital costs, capital as a percentage will go up because we are holding down the others.

And our studies show it may be as much as 9 percent in the next couple of years if we make no changes. What is 7½ now will really be 9 in 2 years.

But basically, what we are talking about is a multiyear—we think it ought to be more like 10 years—phase in into a percentage add-on.

The CHAIRMAN. All right. Now, Dr. Willging, let me ask you this. In your testimony, you state opposition to the House action regarding the return on equity. Give me a little more detail about why you are opposed to their proposal.

Dr. WILLGING. Essentially, our industry is one which is largely investor-based.

The CHAIRMAN. Largely what?

Dr. WILLGING. Investor-based; 80 percent of nursing homes are investor-based. It is in stark contrast to the hospital industry, where the figures are quite the opposite.

If, indeed, we are going to reduce the incentives or eliminate the incentives available to investors to move into this industry, I think we are going to have great difficulties building those additional beds which the demographic figures would suggest we need.

A reduction in return on equity, much like the asset revaluation legislation of last year, has a chilling effect in terms of new investor participation in the nursing home industry.

Studies as recently as a year ago suggest this country may need up to 1.5 million additional nursing home beds by the year 2000. Let's assume it is only half of that. Half of that would translate into 40,000 beds a year.

We are building today 10,000 beds per year. We need more, not less, inducements for investors to come into this industry.

Mr. BROMBERG. Mr. Chairman, could I add something to that?

The CHAIRMAN. Sure.

Mr. BROMBERG. Just simply if you think back years ago to some of the scandals involving highly leveraged health care companies—I think Four Seasons was the name of one of them at the time. We have come a long way in both the nursing home and the hospital industry in terms of seeing highly leveraged companies that were

80 and 90 percent debt and only 10 or 20 percent equity to a situation now where it is much closer to 50–50.

This provision, regardless of need, if it were passed, as it is in the House, any intelligent manager of a company would go out and borrow the money in order to get the interest which would get us back to that high leverage, No. 1, and No. 2, cost Medicare more in the long run because the hospitals feel we have about $20 billion worth of assets financed by investors.

If we simply leverage that money over a several-year period, the interest payment would be much higher on that base than it would be if private investors put their money in. So, there are two reasons in addition to the one Paul mentioned.

The CHAIRMAN. I had come to that conclusion myself. It seems to me inevitably it goes down that trail. If, indeed, the option is you can have the interest and be paid for it and you cannot be paid for the capital, what other alternative do you have?

Mr. BROMBERG. Correct. And all we want is for them to be treated equally. If we get to a prospective rate, they will both be in effect phased out and a single rate will be put in its place, but while it is happening, they will both be part of the hospital specific portion.

The CHAIRMAN. Mr. Owen, a question from Senator Bradley. Do you support a 3-year phaseout in funding for foreign medical graduates? Do you think that hospitals with high concentrations of foreign medical graduates should receive more time to adjust to these changes and financial conditions?

Mr. OWEN. We support a phaseout, Senator Packwood. I think 3 years is a reasonable probable phaseout; but in New Jersey in particular, Senator Bradley's home State, where they have a large number of foreign medical graduates—the largest of any State in the United States—I would think that 5 years would be a more appropriate phaseout.

But, I think, the time is coming where the phaseout is going to occur, and if there is a year's startup time, why then that gives 1 year at least in the start; but we do support a phaseout period. In some States where more than 50 percent of residents are foreign medical graduates, we would support a longer period of time if it is necessary.

The CHAIRMAN. You would almost be willing to go on an ad hoc State-by-State basis then, depending upon the percentage of foreign medical students?

Mr. OWEN. I don't think you can do that because it is only really New York and New Jersey that have the really large numbers. For the rest of the States, and I have traveled around the country talking about this to hospitals, a 3-year phaseout seems to be nationally pretty acceptable, except for New York and New Jersey, where they may need a little more time.

The CHAIRMAN. Gentlemen, thank you. I have no more questions. I appreciate your testimony.

Now, let's conclude with a panel of Gary Thietten, William O'Neil, and Thomas Antone. Mr. Thietten, why don't you go ahead, sir?

STATEMENT OF GARY THIETTEN, PRESIDENT, IDAHO HOME HEALTH AND HOSPICE, INC., TWIN FALLS, ID; AND PRESIDENT, AMERICAN FEDERATION OF HOME HEALTH AGENCIES

Mr. THIETTEN. Thank you. Mr. Chairman, my name is Gary Thietten. I am the president of the American Federation of Home Health Agencies. I am also the administrator of a home health agency, Idaho Home Health and Hospice, also a Medicare-certified hospice in Twin Falls, ID.

Our association is concerned about the implications of the Health Care Financing Administration's restructured cost limits for Medicare-certified home health agencies, in particular the per discipline application of the caps for which HCFA projects a savings of $14 million over 3 years.

We think the disruption of home health agency operations and the loss of beneficiary access that per discipline limits will cause is an awfully high price to pay for the relatively small amount of $14 million.

We predict that this figure will be largely consumed by Medicare reimbursable fees for accountants to shift costs to under cost cap services and for higher institutional costs for patients in areas where home health agencies end up discontinuing the over cap service.

Since Medicare home health agencies are reimbursed for only costs, agencies no longer able to offset the over cap services with savings achieved in other areas will cease furnishing those disciplines over the limits.

Over the past few months, the American Federation of Home Health Agencies has talked to dozens of administrators, many of them located in rural areas around the country. They told us that they most often find themselves over limits in medical social work and the various therapies for a variety of factors beyond their control, including the disproportionate allocation of administrative and overhead costs to less frequently used services based on the costs of providing visits in a discipline rather than on the proportion of services constituted by the discipline; the scarcity of therapists; payment of salaries adequate to attract and retain therapists in rural areas; and the need to compensate therapists for travel time in rural areas and for the increasing amount of time that they must devote to paperwork requirements.

If a home health agency is unable to offset losses on over limit services with below cap disciplines, the home health administrator has several options, including take the losses out of his or her own salary, discontinue services, hire an accountant whose expenses are reimbursable by Medicare to shift the costs completely in accordance with the law to below cost cap services, and shorten the time being spent with seriously ill patients now being seen, thus reducing the quality of service.

To illustrate the problem of the per discipline application, using my own agency as an example, during 1984 I exceeded the limits in one discipline, medical social work.

My agency's aggregate limits were $537,377 while my actual costs of providing the total home health package was $373,230.

With the new limits in effect and in spite of the efficiency of my agency, I may be unable to continue medical social services since I must pay for the losses out of my own pocket.

And I might insert right here that concerning these volume ventilator patients, 90 percent of the 64 MSW visits which I provided during 1984 were to a home ventilator patient, of which we were saving the Medicare Program thousands of dollars.

It is the skill of my social worker that has enabled some seriously ill patients to be deinstitutionalized. Another home health agency of the same size could provide services right at the aggregate limit of $537,377 and still be under the caps in all disciplines.

Such an agency would suffer no losses, while mine would be penalized, although I provided services for $164,000 less than the nonpenalized agency.

Home health agencies do not provide a series of isolated services. Physicians order a coordinated group of services to assure that patients' overall needs are met.

We have never required hospitals to account individually for all of their service centers or suffer penalties in their dietary division or physical therapy department if they don't turn a profit.

We urge you to allow home health administrators the flexibility to manage an integrated program of services.

Specifically, Mr. Chairman, we urge this committee to allow home health agencies to apply their cost limits on an aggregate rather than per-discipline basis, adopt a measure that more than compensates for the $14 million attributed to discipline cost limits, and that is acceptance of Senator Proxmire's Senate bill 1402 which would end the 12 percent add-on for hospitals.

And finally, to begin now to develop a carefully structured prospective payment system for the home health benefit.

Our association has initiated a project, and we will be working over the next few months to develop a viable proposal for prospective payment.

We would like to work with you to save real money for the Medicare Program and relieve home health agencies of the enormous regulatory and paperwork burdens that make a Medicare home health visit twice as costly as visits to other home health patients.

Thank you.

The CHAIRMAN. Thank you, sir. Mr. O'Neil.

[The prepared written statement of Mr. Thietten follows:]

STATEMENT OF GARY L. THIETTEN, PRESIDENT, AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

Mr. Chairman, my name is Gary Thietten. I am the President of the American Federation of Home Health Agencies. I am also President of Idaho Home Health and Hospice in Twin Falls, Idaho. I am very pleased to have this opportunity to present testimony to the Senate Finance Committee as you consider deficit reduction proposals for the next three fiscal years.

Home health care is a humane and cost-effective alternative to institutionalization for elderly and disabled Americans. The home health benefit is inevitably growing as the population ages; home health agencies develop the ability to care for more complex cases; and Federal policies such as prospective payment for hospitals encourage the use of non-institutional services.

Despite strong Congressional and public support, we find the greater use of home care services cited as justification by the Health Care Financing Administration for excessive stringency in development of policies to govern the home health benefit. We believe that it makes no sense to pursue policies which encourage deinstitutionalization while reducing reimbursement and hindering the ability of home health agencies to deliver the medically necessary services patients require upon discharge.

We are particularly concerned about the implications of HCFA's restructured cost limits for home health agencies for cost report periods beginning on or after July 1, 1985. The new limits contain two significant changes in the methodology for setting caps. First, limits are to be calculated and applied for each discipline, rather than on an aggregate basis. Second, the limits are set at 120 percent of the mean per visit costs, instead of at the 75th percentile. The limits are to be further reduced to 115 percent of the mean July 1, 1986, and to 112 percent of the mean effective July 1, 1987.

A preliminary GAO report to Senator John Heinz earlier this year indicates that Medicare patients are leaving the hospital in a poorer state of health. We believe that it would be penny wise and pound foolish to reduce reimbursement just as home health agencies are seeing sicker patients entering into the home health care system. Medicare does not provide a higher level of reimbursement for complex visits of a longer duration required by more severely ill patients. With reduced limits, many HHAs may determine that admission of acutely ill beneficiaries is a burden they are unable to bear.

We anticipate serious financial problems for many home health agencies as reimbursement is ratcheted down even while the health inflation index remains at around seven percent. And we believe that it makes no sense to reduce reimbursement at the same time HCFA is imposing costly and time consuming new burdens on HHAs, while agencies face a maze of confusing directives from their current fiscal intermediaries and added expenses when they transfer to the new regional intermediaries.

(It is becoming increasingly apparent that a single new requirement for provision of "minimum" data elements, Forms 485 and 486, will be enormously costly. Skilled professionals must complete these forms, reducing many highly paid personnel to paper pushers. We doubt that many FIs will have the manpower to sort through the millions of these forms that will come flowing into their offices; but HHAs must fill them out as if reimbursement depends upon them, for in an undetermined percentage of cases, it will. The cost of implementing the new forms will throw a number of agencies over the cost limits.)

Additional costly labor and paperwork burdens combined with inflation in rent, utilities, transportation, and other costs will place many providers in an untenable position. Their costs will rise as their reimbursement is reduced.

We urge the Senate Finance Committee to look not just at the bottom line on savings projected for the next few fiscal years, but to consider the long term cost of institutional services for patients denied home health care. Medicare certified home health agencies cannot provide services for which they are not adequately reimbursed. We urge you to consider the Medicare home health benefit within the context of the enormous savings achieved through shortening of hospital stays and preventing institutionalization for disabled and elderly Americans.

Per Discipline Limits

AFHHA believes that per discipline rather than aggregate application of the cost caps will lead directly to higher institutional costs for the American taxpayer. In issuing the regulations revising the cost caps, the Secretary of Health and Human Services indicated that application of the limits by discipline will result in about 70 percent of HHAs exceeding the caps in at least one service. This represents over 3600 agencies, an extraordinarily large number. The Secretary acknowledged that reducing the limits for future years below 120 percent of the mean will affect even greater numbers of HHAs. Faced with such a startling increase in the number of agencies that will be over limits, we believe that it is the responsibility of the Secretary to demonstrate that her decision is in the best interests of the Medicare program. She suggests that most HHAs are inefficiently operated; however, she provides no data to support this contention. We firmly believe that the vast majority of HHAs are managed in a cost effective manner. Certainly there are HHAs that are inefficient, but in the absence of any evidence or documentation, we are asked to accept the Secretary's contention on faith alone. If her assumption is not correct, the likely consequence of a precipitous drop in the caps and application on a per discipline basis will be a loss of access to services and a reduction in the quality of care for Medicare beneficiaries. Since HHAs are cost reimbursed, there is no profit in providing services to Medicare beneficiaries and no incentinve to continue provision of over cap disciplines. Many HHAs no longer able to offset over-cap services with savings achieved in other disciplines will cease furnishing service in disciplines over the limits. HHAs most often find themselves over limits in medical social work and the various therapies. They are over caps for a variety of factors beyond their control:

- o the disproportionate allocation of administrative and overhead costs to less frequently used services, based on the cost of providing visits in a discipline rather than on the proportion of services constituted by the discipline
- o the scarcity of therapists
- o payment of salaries adequate to attract and retain therapists in rural areas
- o the need to offer full time employment to therapists and MSWs in order to secure their services, even though an HHA does not have the equivalent of a full time work load in a particular discipline
- o the need to compensate therapists for travel time in rural areas and for the increasing amount of time that they must devote to paperwork requirements

If HHAs are unable to offset losses on over-limit services with below-cap disciplines, an agency administrator will have several options:

- o take losses out of his/her own salary
- o drop over-cap services
- o secure a bank loan, the interest of which is reimbursable by Medicare
- o hire an accountant, whose expenses are reimbursable by Medicare, to shift costs—completely in accordance with the law--to below cap services

- o increase utilization of over-cap services, for example by requiring all counseling to be performed by an MSW rather than routinely by skilled nurses
- o shorten time spent with patients and thus reduce the quality of services provided
- o discharge highly paid experienced personnel and replace them with lower-salaried employees

To illustrate the problem of the per discipline application, using my own agency as an example, during 1984, I provided medical social work visits at a cost of $74.27 per visit. This was the only discipline that exceeded the cost caps. My agency's aggregate limits were $537,377, while my actual costs were only $373,230. I was able to provide home health services to Medicare patients at a significant savings to the Federal government. With the new limits in effect, notwithstanding the efficiency of my agency, I may be unable to continue to furnish MSW services since I must compensate for the losses out of my own pocket. The skill of my MSW has enabled some seriously ill patients to be deinstitutionalized. Another HHA of the same size could provide Medicare services right at my aggregate limit of $537,377 and still be under caps in all disciplines. Such an agency would suffer no reimbursement losses, while mine would be penalized, although I provided services for $164,000 less than the non-penalized agency.

We are no longer dealing in the realm of speculation. HHAs all over the country anticipate a devastating impact on their ability to deliver services and on access of beneficiaries to health care. Over the past several weeks, our association has talked to dozens of administrators, many of them located in rural areas, in an attempt to assess the impact of the restructured cost limits. The following are representative examples of what we have been told:

- o a home health agency in Wyoming will be forced over caps in the therapies because of the "phenomenal travel time" involved in making visits; to see many of their patients, agency personnel have to travel to remote areas, up to 70 miles one way.
- o An administrator in Montana reports that therapists and MSWs are as "rare as hen's teeth" in her area, hence they can command high salaries. Many HHAs in her state will drop these services she believes, with loss of access to the very rehabilitative services beneficiaries need to remain in the community, and institutionalization for patients unable to receive needed home health care.
- o An administrator in North Dakota is reimbursed the same for a visit provided in the town where her agency is located as for a visit to a patient 60 miles away. She must pay her therapists for travel time, throwing her considerably over caps in some disciplines. Her agency can provide services under the caps--by ceasing to provide services in the more rural areas, dropping the therapies, and/or reducing the quality of care and the time spent with the sicker patients she is now admitting, discharged from hospitals under DRGs. Her agency is the only home health provider in much of her area of the state.
- o An administrator in Colorado anticipates that county commissions and agency boards of directors will direct HHAs to drop services which are money losers. A number of agencies will stop caring for Medicare patients altogether, since reimbursement is being cut at the very time HHAs are being put in a position of having to accept "dangerously" ill patients being discharged under DRGs. She stated, "You would have to be crazy to provide services if you can't break even."

- An HHA in California stated that every American business is "efficient in some areas and less so in others." HCFA's new limits will "give you no credit where you are efficient" but penalize you for being over limits in some disciplines for reasons outside of your control. "Since we have no profits to offset such losses, we will go bankrupt." His HHA provides the only home health services in large areas of his county.

Past experience indicates that exceptions to the limits for agencies such as these will also be as rare as hen's teeth. One major accounting firm indicated to us that it has met with no success in obtaining exceptions to the cost limits for new agencies, both urban and rural, whatever the merits of the request. A fiscal intermediary told us that based on past experience, only an act of God could lead to exceptions for rural agencies.

The per discipline approach presumes that home health agencies provide a series of discreet services with no relationship among the various disciplines. This is not the case. Physicians order a coordinated group of home health services to assure that patients' overall needs are met. In fact the Medicare statute mandates that certain services may only be furnished in conjunction with others; for example, home health aide services, occupational therapy, and medical social services can only be furnished where a patient requires skilled nursing, physical therapy, or speech therapy. In keeping with this concept, it is wrong to evaluate home health care by each discipline since the Medicare statute itself conceives of patients receiving a mix of disciplines in an integrated plan of care. The most feasible method of evaluating the appropriateness of the cost of home health care is to evaluate the aggregate cost of services. To do otherwise constitutes a violation of Section 1861(v)(1)(L) of the Medicare Act, which requires the cost limits to reimburse all providers for the costs necessary for the efficient delivery of services.

We urge you to allow home health administrators to manage an integrated home health program of services, not six separate businesses. An administrator should be judged on overall performance and not forced to become a manipulator of the cost cap system in order to survive.

HCFA has never before fragmented Medicare services, for example by requiring that hospitals account individually for all of their service centers, or suffer penalties if their dietary division or physical therapy department do not turn a profit. Yet fragmentation is precisely the impact HCFA's new limits will have on the Medicare home health benefit.

Out of the total $440 million in savings projected over three years for the restructured cost limits, HCFA attributes only $14 million to the per discipline application of the limits. We believe that the reduction of access for beneficiaries and the fragmentation of home health services is an awfully high price to pay for such a relatively small amount of money. Numerous home health administrators will be over caps by no more than a thousand or so dollars, but will be unable to absorb the loss. Few can afford to pay such losses out of their own pocket or have any incentive to do so.

We will find that sophisticated home health agencies with access to knowledgeable CPAs will be able to shift costs out of over-cap centers, while less sophisticated HHAs, many in rural and underserved areas, will simply drop services. We predict that HCFA's projected savings will be largely consumed by Medicare-reimbursable fees for CPAs and for higher institutional costs to the government in areas where

HHAs do not have access to the most sophisticated financial advice. And elderly and disabled Americans will pay a price in human terms that is beyond calculation.

RECOMMENDATIONS

The American Federation of Home Health Agencies urges the following action to ensure the continued availability of Medicare home health services to beneficiaries and the cost effectiveness of the benefit:

- Enact a provision to allow HHAs to apply their cost limits on an aggregate rather than per discipline basis.
- Accept Senator Heinz' bill S.1450 to postpone implementation of the new cost cap structure for a year. We believe that HHAs will accept the challenge of meeting limits at 120 percent of the mean, but the precipitous retroactive introduction of the change has not allowed a transition period for agencies to make adjustments in their operations. The one year hold will also enable Congress to explore more feasible reimbursement methodologies for home health care.
- Accept Senator Proxmire's S.1402 to end the add on for hospital based HHAs, and thereby achieve substantial savings without disrupting the home health benefit. Our association represents a number of hospital based HHAs, but we believe as a matter of equity that all home health agencies should compete on an equal basis and be held to the same level of efficiency.
- Use the transition time provided by S.1450 to develop a viable prospective payment system for the home health benefit. AFHHA will be working over the next few months to develop a carefully structured proposal for prospective payment. We hope to work with you to save real money for the Medicare program. We believe this can be done by relieving HHAs of the enormous regulatory and paperwork burdens that make the cost of a Medicare home health visit twice as costly as visits to other home health patients. We fear that every year that passes without enactment of prospective payment will witness the further nickel and diming to death of the Medicare home health benefit.

STATEMENT OF WILLIAM C. O'NEIL, PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION, NASHVILLE, TN, ACCOMPANIED BY H. ROBERT HALPER, ACLA COUNSEL

Mr. O'NEIL. Thank you, Mr. Chairman. My name is William O'Neil. I am president of a major laboratory company headquartered in Nashville, Tennessee. I am also president of the American Clinical Laboratory Association, an organization of federally licensed and regulated independent clinical laboratories.

I am accompanied by Bob Halper, here on my right, who is the ACLA counsel.

I want to thank you very much for the opportunity to testify today. We have also submitted a lengthy written statement, which we would like to be included in the record.

Our purpose in testifying here today is to comment on two proposals to revise the Medicare laboratory fee schedule reimbursement system which was adopted by Congress just 1 year ago.

This new fee schedule approach of a year ago radically altered the way in which Medicare pays for testing services to laboratories and hospitals.

The first proposal before you now would freeze Medicare laboratory fee schedules at the rates in effect on June 30, 1985. We think this proposal is grossly unfair, and we vehemently oppose it for the following reasons.

As a result of last year's Deficit Reduction Act, independent laboratories have already sustained cuts, and I repeat cuts, not a freeze, of 25 to 40 percent in the rates that we were paid for tests prior to this new system coming in.

This has had a major impact on most of the laboratories across the country. Some other providers, of course, have been frozen, which means they were kept at the same level, and laboratories were singled out, I believe, somewhat unfairly as the only ones to receive such a cut last year.

As part of a quid pro quo for supporting that cut last year, Congress promised us two things: an annual update in those fees, and now it is being proposed that we take that back and renege on that promise; and the second thing is you directed the Health Care Financing Administration to simplify the billing process.

It is now 14 months later. No simplification has been done. As a matter of fact, it appears to us that HCFA is letting local carriers even go the other way and make the billing system more complex.

In light of all these factors, we think it is unfair and a breech of faith to further punish us by imposing a freeze.

We also understand that you may be considering measures of some sort of ceiling or a cap on the current fee schedules that are in effect. We oppose this one for the same reasons as we oppose the freeze.

A cap approach would cause further reductions in fees, and that is just what it is. It is really not a cap or a ceiling. For most laboratories, it would be a further reduction on top of the big decreases that we took a year ago.

We continue to be sensitive, however, to the need for saving money and helping to reduce the deficit. We do have a number of proposals, some of which are included in our written statement, but there are two others that I would like to put forth here today.

One is to direct HCFA and give them a timeframe—a real timeframe—to implement streamlining of this complex billing process for very low average bills that we submit to them.

This will save millions of dollars on their side and should help us to restrain our costs over the long term.

And that streamlining process, I ask you, to direct them to make it real and not cosmetic.

The second thing would be to direct HCFA to accelerate its study to reduce the number of Medicare carriers around the country to perhaps two to four. This will make things an awful lot easier for processing claims for everyone, and I believe again will save many, many millions of dollars.

In summary, we respectfully ask that you leave intact the laboratory fee schedule system that you legislated just last year and leave it alone—follow it out as you have in the legislation.

Clinical labs are the only health care entity which have sustained real cuts and cuts of a substantial magnitude. We think we have done our share.

To impose a freeze or further cuts now, we think is punitive and would severely damage our ability to serve the Medicare patients of this country.

Thank you very much.

The CHAIRMAN. Thank you, sir. Mr. Antone.

[The prepared written statement of Mr. O'Neil follows:]

STATEMENT OF
WILLIAM C. O'NEIL, JR.
PRESIDENT
AMERICAN CLINICAL LABORATORY ASSOCIATION
On Deficit Reduction Proposals

My name is William C. O'Neil. I am President of the American Clinical Laboratory Association ("ACLA"), a trade association of federally regulated independent laboratories. All of ACLA's members are certified pursuant to the Medicare Conditions for Coverage of Services of Independent Laboratories and therefore have extensive experience in providing services to Medicare beneficiaries. Before I begin my substantive remarks, I want to thank the Committee for allowing me to testify on a variety of laboratory-related deficit reduction proposals.

This statement provides ACLA's views on: 1) changes to the fee schedule reimbursement methodology (pp. 2-17); 2) extension of the mandatory assignment provisions that are now applicable to independent and hospital laboratories to cover testing performed or supervised by physicians as well (pp. 17-19); 3) adoption of quality assurance standards to apply to physicians' office testing (pp. 19-20); 4) disallowance of Medicare reimbursement to laboratories for tests referred by physician owners (pp. 20-21); 5) adoption of a requirement that the Health Care Financing Administration ("HCFA") reimburse for the expenses that laboratories incur in travelling to nursing home or home bound patients to collect diagnostic specimens (pp. 22-24); and 6) HCFA's plan to experiment with competitive bidding as a procurement mechanism for Medicare laboratory services (pp.

24-29). In addition, at Section II, pp. 15-21, ACLA offers a variety of budget savings proposals.

I. CHANGES TO FEE SCHEDULE REIMBURSEMENT METHODOLOGY

1. Proposed Fee Freeze

The Administration has proposed freezing the Medicare laboratory fee schedule at the rates in effect on June 30, 1985. I cannot overstate ACLA's opposition to this proposal. Laboratories have already sustained an overall reduction of 40% of the amounts they previously received in payment for testing services provided to ambulatory Medicare beneficiaries as a result of enactment of the Deficit Reduction Act of 1984 ("DRA"). Thus, just one year ago, pursuant to Section 2303 of that statute, HCFA established fee schedules set at 60% (or in the case of hospital outpatient testing, 62%) of the Program's prior maximum payment levels ("prevailing charges").

Although the President did not sign the DRA into law until July 18, 1984, HCFA retroactively implemented the fee schedule reimbursement methodology, along with its reduced reimbursement rates, and applied them to all clinical testing services provided to ambulatory beneficiaries on or after July 1, 1984. As a result, HCFA instructed carriers, the Medicare contractors charged with the responsibility of determining reimbursement levels and making payments, to withhold payment to laboratories until fee schedule levels had been calculated. The decision to implement the fee schedule reimbursement methodology retroactively caused considerable disruption to the industry as laboratories did not receive Medicare payments for a number of months thereafter. In addition, laboratories are still adjusting to the reduced payment rates.

Congress was not insensitive to the problems that laboratories might experience as a result of the reduction in reimbursement levels. Recognizing the severity of this reimbursement reduction and the fact that so long as there is any inflation laboratories will experience increasing costs, the DRA promised an annual adjustment in these reduced reimbursement rates to reflect the changes in the Consumer Price Index.1/ Now, little more than one year later, the Administration proposes that this annual update should be repealed, at least for the period beginning July 1, 1985 and ending either on June 30, 1986 or September 30, 1986. To repeal this adjustment for that period, after so significantly reducing reimbursement levels less than one year ago, is to ask laboratories to bear an unfairly heavy burden in this nation's deficit reduction efforts. While we recognize the urgency of reducing the deficit and indeed actively supported enactment of the DRA as our industry's contribution to

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1/ The DRA provision states in relevant part that:

> [T]he Secretary shall set the fee schedules...for the 12-month period beginning July 1, 1984, adjusted annually by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average)...

Section 2303(d), amending Section 1833(a)(2) of the Social Security Act.

reducing that deficit, we feel that the contribution we have already made is sufficient.

In supporting the 1984 DRA, ACLA was cognizant that laboratories would sustain reduced per test Medicare payments. However, ACLA recognized that the laboratory payment provisions contained in the Act promised certain benefits to laboratories that would, if implemented, blunt some of the sting of the reimbursement reductions. Thus, the Act directed HCFA to simplify the Medicare billing, payment and collection process in an effort to reduce the costs incurred by both laboratories and the Program that are associated with these functions. HCFA had previously conceded that unnecessary costs attend these functions. In a report issued by an intra-agency HCFA laboratory Task Force on February 15, 1984,[2/] the Task Force acknowledged that HCFA's billing, collection and payment procedures could and should be simplified, stating:

> The Task Force believes that the final step needed to assure program and beneficiary savings is extensive effort to simplify claims processing requirements, particularly for independent laboratories. Among the changes proposed by the Task Force are:

[2/] This Task Force report formed the basis for the DRA laboratory payment provisions. Indeed, the Task Force's recommendations were essentially incorporated in toto in the Act. The Task Force began studying the industry and the relationship between the industry and Medicare in October 1982. Thus, its report and the recommendations contained therein are the culmination of 17 months of study, investigation, on-site visits and thought. It is the best exposition of the laboratory industry that ACLA has seen.

> (1) deletion of the requirement for a diagnosis on independent laboratory claims, as long as the name of the referring physician is included on the bill;
>
> (2) requiring carriers to accept and process periodic billings for all of a laboratory's Medicare patients rather than requiring individual claims for each patient;
>
> (3) limiting the patient-specific information required to the minimum that will permit identification of the beneficiary;
>
> (4) instituting prompt payment practices; and
>
> (5) requiring carriers to provide, along with the explanation of Medicare benefit, the laboratory's invoice or specimen accession number to facilitate its reconciliation of Medicare payments with Medicare billings.

Report of Laboratory Task Force, p. 25.

The laboratory payment provisions of the Deficit Reduction Act incorporated these recommendations by requiring:

> The Secretary [to] simplify the procedures ... with respect to claims and payments for clinical laboratory tests so as to reduce unnecessary paperwork while assuring that sufficient

> information is supplied to identify instances of fraud and abuse.[3/]

Section 2303(h).

The Conference Committee Report added that this "provision does not require patient diagnosis to appear on bills." Deficit Reduction Act of 1984, Cong. Rpt. 98-861, 98th Cong., 2d Sess., p. 1308.

ACLA viewed these directives as the _quid pro quo_ for not opposing the DRA because of its call for reduced reimbursement levels. However, although ACLA has been working with HCFA since last July in an effort to obtain the mandated simplification, nothing has yet happened. None of the Task Force's simplification recommendations have been implemented, and a number of carriers continue to require laboratories to supply

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[3/] The Task Force recognized the importance of detection of fraud and abuse and made the following observation: "While the Program necessarily has to concern itself with identifying and eliminating instances of fraud and abuse and protecting the overall fiscal integrity of the Program, the Task Force believes that instances of fraud and abuse should be viewed as the exception rather than the rule. Billing simplifications need not undermine the Program's ability to eliminate questionable practices. Rather they might well eliminate some of the underlying reasons for such practices by reducing suppliers' costs of doing business with the Medicare Program. Additionally, they represent a good faith effort to rationalize Program payment in a manner that is to all parties' advantage. From this perspective, it may be useful to handle audit and program validation efforts by periodic sampling and linking of laboratory and physician claims processing procedures to try to identify every questionable claim for diagnostic testing." _Report of Laboratory Task Force_, p. 26.

diagnosis information.[4/] Thus, ACLA's hopes have gone unrealized that the reduced reimbursement levels would be coupled with claims processing simplifications that would reduce both laboratory and programmatic administrative costs. Rather than freeze or modify the fee schedules, Congress should direct HCFA to comply with the DRA's simplification directive, a step that would save money not only for laboratories, but for the Program as well.

Moreover, in addition to failing to simplify billing and collection procedures, HCFA has also failed even to propose regulations implementing the discretionary authority provided to the Secretary by the DRA. To eliminate the promised annual update of the fee schedule in the face of the unfulfilled promise of billing simplifications and the failure to promulgate implementing regulations is to tax laboratories with still more reimbursement cuts (the freeze in reality amounts to a reimbursement reduction of 4.1%, the CPI July 1, 1985 update) without any of the offsetting benefits that the DRA was supposed to guarantee. Stated simply, laboratories are being squeezed and the pinch is too tight.

The squeeze that independent laboratories are being asked to sustain is even more crippling because independent

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[4/] ACLA does not challenge HCFA's good faith. HCFA officials have met frequently with ACLA representatives to achieve simplification. However, despite good intentions, the system continues to be unnecessarily cumbersome, burdensome and expensive.

laboratory charges have not increased as quickly as the laboratory charges of other members of the health care industry. Indeed, the charges of independent laboratories, when compared with other laboratory providers, have escalated at a lower rate. Thus, the Task Force report revealed the following statistics:

Diagnostic Laboratory Charges To Medicare

Specialty	Average Annual Compound Growth Rate 1976-80
Internal Medicine	7.6%
Independent Labs	6.3%
General Practice	6.7%
Clinic	7.0%
Cardiovascular	15.3%
Family Practice	6.4%
All Others	12.8%

Report of Laboratory Task Force, p. 20.

As these statistics demonstrate, the price to Medicare of independent laboratory services, in general, escalated considerably less sharply during the 1976-80 period than did the amounts Medicare paid others for testing services. Of the specialties seeking payment from Medicare for laboratory testing services, independent laboratories escalated the least, rising a mere 6.3%, well below the health care inflation rate for the period. Because Medicare payments to independent laboratories have remained relatively constant, they are likely to have difficulty incorporating a fee freeze.

Even without the proposed freeze, ACLA members report that they are receiving substantially less per test from Medicare for services than they did before the 40% reduction, as the following chart of the most commonly ordered tests reveals:

Largest Reduction Experienced
By ACLA Members

Test	Reduction
CBC	$5.80
Platelet Count	$5.85
Sodium	$5.90
Potassium	$6.52
Glucose	$11.19
Cholesterol	$11.00
T-4	$8.75
Urinalysis	$2.50
Digoxin	$19.50
Prothrombin Time	$4.80
SMA-12	$9.75
SMAC	$12.33
SMAC-20	$13.65
Tryglycerides	$9.70
Electrolytes	$10.00
Serum Iron	$9.00
VDRL/RPR	$7.13
BUN	$3.95
Calcium	$7.25
Uric Acid	$3.55

These reductions were calculated by taking each laboratory's payments from Medicare during May and June of 1984 (before imposition of the fee schedule), adding the 20% that laboratories had received from co-insurance payments and subtracting from that figure current fee schedule amounts. To ask laboratories to forego the 4.1% is to increase the impact of these already substantial reductions.[5]

In summary, ACLA opposes the proposed freeze on the Medicare laboratory fee schedule for five reasons:

First, laboratories have already sustained an overall reduction of 40% of the amounts that they previously received in payment for testing services provided to ambulatory Medicare beneficiaries as a result of enactment of Section 2303 of the DRA. Thus, laboratories have suffered large, actual reductions in Medicare payments, as opposed to cuts in the amount of increase in reimbursement levels sustained by other providers of health care.

Second, when Congress approved these reductions in laboratory payments, it promised an annual update of the fee schedules to help laboratories meet increasing costs. Laboratories have made business plans and investments in reliance on this update. Because of the substantial per test reductions that laboratories have already incurred, it would be unfair to deny laboratories the promised update.

Third, Congress mandated, as a quid pro quo for the DRA required reimbursement reductions, that the Health Care Financing Administration simplify the billing mechanisms that currently overburden and overtax both the Program and laboratories. Despite this directive, to date HCFA has failed to adopt any simplification measures. To eliminate the promised fee schedule update in the face of the unfulfilled promise of billing simplification would tax laboratories with even deeper reimbursement cuts without any of the offsetting benefits that the DRA was supposed to guarantee. Moreover, it would be a breach of faith for Congress to freeze the laboratory fee schedules in the face of HCFA's failure to act and the statutory guarantee of an annual update of the fee schedule amount to reflect the percentage of increase (or decrease) in the Consumer Price Index.

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[5] That these reductions are substantial is confirmed when one recognizes that the levels of payment that are authorized by the fee schedules are small dollar amounts. For example, one of the fee schedules pays $7.20 for a CBC. Thus, a reduction from $13.00 to a reimbursement rate of $7.20 is significant.

Fourth, independent laboratory charges have not increased as steeply as the charges of other members of the health care industry. Thus, the proposed freeze will work an especially great hardship on independent laboratories, which represent one of the most competitive segments of the health care industry.

Finally, the effects of the proposed laboratory fee freeze, in light of the recent substantial reimbursement reductions that laboratories have experienced, are obvious. The proposal threatens the ability of laboratories to continue providing high quality services to Medicare beneficiaries. These results are so apparent that there is no need to dwell on them.

2. Proposed Fee Schedule Ceilings

The House of Representatives' Committee on Interstate and Foreign Commerce has reported a budget measure that would clamp ceilings on fee schedule reimbursement while retaining this year's DRA-promised 4.1% increase. We further understand that the goal of these proposals is to standardize fee schedule amounts which reportedly vary widely across the country. This standardization would apparently result in a reduction of high fee schedule rates but would not affect low fee schedule limits. While ACLA is gratified that the Commerce Committee sought ways to retain this year's CPI update, we oppose any change to the DRA fee schedule reimbursement methodology, particularly if such change were to result in reduced reimbursement for some tests but not increases in such reimbursement for others.

First, as noted above, laboratories have already sustained a substantial reduction in the amounts that they formerly received for Medicare testing services. Further reductions would exacerbate the difficulties that laboratories are currently experiencing in adjusting to lowered payment levels, particularly because HCFA has failed to simplify its billing and collection procedures.

For example, laboratories serving nursing home patients have had particular difficulty in coping with reduced reimbursement levels because the costs of providing these services are especially high as discussed on pp. 22-24 of this statement. Thus, such laboratories must often have trained phlebotomists make special trips to nursing homes to collect specimens for emergency testing at odd hours of the day and night. The laboratory must then assure that technologists are available to perform the assay even if testing is not being routinely conducted. Collecting the specimen and opening the laboratory under such circumstances is expensive, and providing these services has grown increasingly difficult in the face of reduced reimbursement. The Commerce Committee proposed ceilings will significantly compound these problems and may make it even more difficult for laboratories to continue offering these services, particularly in high cost areas. As demand for these services has grown and as it is far more expensive to transport a patient by ambulance to a hospital for such testing, any proposal that would discourage laboratories from providing these services is poor policy.

Second, the fee schedule methodology was designed to lower reimbursement based upon the charge data Medicare utilized in calculating reasonable charge payments prior to enactment of the DRA. This methodology made sense as it recognized the effect of competitive pricing and the fact that the costs of providing testing services, which may vary from area to area, were built into laboratory pricing policies and thereby were reflected in the fee schedule limits. To cap arbitrarily the fee schedule levels by reference to a "median" or other artificial limit would fundamentally alter Medicare's Part B laboratory reimbursement philosophy (which has always been based on laboratory charges) and could injure laboratories located in high cost areas, particularly if the methods used to arrive at the ceiling do not consider the frequency with which each specific test is performed. Moreover, the proposal would not provide relief to laboratories subject to comparatively low fee schedules.[6/]

Third, the reported discrepancies in the fee schedule limits are not unprecedented. As the fee schedules were calculated from prevailing charges, it is apparent that the prevailings in effect on June 30, 1984 also varied widely. These prevailings reflected marketplace realities, and no one ever commented on the variations. The only difference now is that fee schedule amounts are more visible than prevailing charges were. Nonetheless, ACLA has seen no evidence to suggest that these

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6/ For example, the fee schedule utilized in Maryland is reported to be significantly lower than the fee schedules used in the surrounding states. There is reason to believe that when the Maryland carrier calculated the fee schedule, it failed to include hospital non-patient charge data, as it was required to do, thereby skewing its computations and resulting in lower rates than would have been obtained had the carrier complied with the mandated formula for determining fee schedule levels. Similarly, Michigan, a _de facto_ direct-billing state, and New York, an actual direct-_billing_ state, have lower than average fee schedules, despite the directive in the DRA conference report that: "The conferees intend that in those States that already require direct billing for laboratory services the Secretary will take into account the fee levels in surrounding States when establishing the fee levels in direct billing States." Deficit Reduction Act of 1984, 98th Cong., 2d Sess., Rpt 98-861, p. 1306. HCFA officials have conceded that they did not direct carriers to comply with this instruction.

variations are unreasonable *per se* or that they justify amendment of the laboratory payment provisions of the DRA.

Fourth, HCFA already has authority to develop regional fee schedules, pursuant to the DRA. Section 1833 (h)(1)(3) of the Social Security Act directs that the fee schedules "be established on a regional, statewide or carrier service area basis (as the Secretary may determine to be appropriate) for tests furnished during the period beginning on July 1, 1984 and ending on June 30, 1987." This provision obviates the need for any additional statutory revisions. Thus, if HCFA feels that the fee schedules need to be adjusted, it can go to regional, rather than carrier-wide, schedules. However, if such a change is to occur, the frequency with which each test is conducted must be considered and the calculations should be conducted using HCFA's formula for determining prevailing charges. Frequency must be considered to assure that the fee schedules will be set at fair and adequate levels.

Finally, when Congress enacted the fee schedule provisions, it envisioned a three-year transition to a nationwide fee schedule.[7/] Only the first year of that transition has elapsed, and yet proposals are being discussed to reduce further fee schedule reimbursement. Given the fact that HCFA has not yet

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[7/] The adoption of a ceiling on fee schedule reimbursement could affect calculations of the nationwide fee schedule. Naturally ACLA is concerned about any proposal that might affect the nationwide fee schedule in a fashion that is not understood by the laboratory industry.

proposed implementing regulations or corrected its expensive billing and collection procedures, such proposals are grossly unfair. If increased Medicare savings are necessary, they should be obtained by implementing the proposals discussed at Section II of this Statement.

II. ACLA BUDGET SAVINGS PROPOSALS

Despite ACLA's opposition to the proposed freeze and fee schedule ceilings, we are sensitive to the need to cut the federal deficit. Thus, ACLA offers five alternative measures that, if implemented, would reduce Medicare outlays for laboratory testing services. These proposals relate to the amounts that Medicare pays for testing services as well as incentives that currently exist for physicians to order more tests than may be appropriate or medically necessary.

First, ACLA recommends that Congress reduce the fee schedules applicable to hospital outpatient testing from 62% of prevailing charges to 60% of prevailing charges. Such a reduction would set hospital outpatient testing reimbursement at the same level as services provided by independent and physicians' office laboratories as well as by hospital laboratories to nonpatients.[8] ACLA has never understood the need for a higher fee schedule for hospital outpatient testing and believes that substantial reductions in Medicare outlays could be achieved by making hospital outpatient testing reimburseable pursuant to the same 60% fee schedule as applies to independent, physician office, and hospital non-patient laboratory testing.

In addition to these savings, the proposal is sound policy as it would result in site-neutral reimbursement, a concept endorsed by the Administration and long sought by ACLA. The principle underlying site-neutral reimbursement is that the same payment rules should apply to all providers and suppliers of the same service. To pay hospital outpatient testing at a higher fee schedule than applies to other laboratory testing services is to provide incentives for the provision of increased services by hospital outpatient departments. Medicare reimbursement policy should not provide any incentives that favor one segment of the market over another. Thus, in addition to achieving savings, this proposal would place all laboratory competitors on an equal footing.

For the same reasons, ACLA offers its second proposal -- elimination of those provisions of the DRA that would end the fee schedule reimbursement methodology for hospital outpatient clinical laboratory testing services on July 1, 1987. We strongly favor repeal of this sunsetting provision contained in Section 2303(d) of the Act. During consideration of the DRA, ACLA opposed the sunsetting provisions, as we, like the Administration, have consistently favored adoption of uniform laws, regulations and rules applicable to all laboratories, regardless of the laboratory's site. Thus, we see no reason for treating hospital outpatient testing differently from testing services provided to Medicare ambulatory patients by independent or physicians' office laboratories. Moreover, adoption of this proposal is likely to yield additional savings. Finally, it makes no sense to require Congress to reauthorize application of the fee schedule reimbursement methodology to hospital outpatient testing in 1987.

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[8] "Non-patients" are typically patients of physicians who choose to send specimens to a hospital for testing. In this situation the hospital laboratory acts like an independent laboratory. A "hospital outpatient" is one for whom the hospital maintains a hospital record and for whom hospital employees provide a service. Typically, a hospital outpatient goes to the facility for specimen collection and has some pre-existing relationship with the hospital.

In addition, current Medicare laboratory policy creates incentives for physicians to engage in arrangements that lead to overutilization of testing services.[9] Thus, ACLA's third proposal is that laboratory testing which is performed or supervised by physicians should be subject to the same mandatory assignment requirements that now apply to hospital and independent laboratories, as a result of the DRA.

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[9] That physicians tend to overutilize is confirmed by a recent report of the Office of Inspector General on "Using the Computer Against Fraud and Abuse in Medicare and Medicaid" (May 1985). In reviewing comments of 1300 respondents to a survey of federal, state and private organizations, the report identified major program vulnerabilities and observed that "of the numerous combinations among health care providers and vulnerability categories, the one most frequently referenced was excessive services furnished by medical practitioners and hospitals. Within this grouping of health providers, the survey respondents identified inpatient hospitals and physicians most frequently susceptible to this type of abuse ..." pp. 4-5.

Currently, hospital and independent laboratories must accept assignment of Medicare patients' rights to reimbursement and must directly bill the Program for those payments. In establishing these requirements, however, the DRA exempted laboratory tests performed or supervised by physicians from the mandatory assignment provisions. This exemption has encouraged the formation of additional and more extensive physicians' office laboratories as well as shared service laboratories[10/] to enable these physicians to continue to profit from laboratory testing because physicians may bill Medicare beneficiaries for services performed in physicians' testing facilities. This loophole allows physicians operating office laboratories to charge uncontrolled prices for laboratory tests with beneficiaries only

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[10/] A shared service laboratory is a laboratory established by physicians who do not share a practice but who combine to form a laboratory to perform testing for the patients of the physician owners. HCFA has suggested that it may plug this loophole once it promulgates regulations implementing the discretionary portions of the DRA laboratory payments provisions; however, as noted above, these regulations have not even been proposed.

receiving from the Program 80% of the fee schedule price.[11/] Moreover, because the absence of mandatory assignment requirements applicable to physician's office testing has led to the proliferation of office laboratories, increased utilization of testing by those physician lab operators is likely to occur. There is little doubt that physician involvement in testing tends to increase utilization because of the financial benefits that result from such testing.[12/] Needless to say, when increased ordering occurs, Medicare outlays escalate.

Hand-in-hand with the loophole created by the absence of mandatory assignment is the puzzling fact that Medicare does not require that physicians' office laboratories comply with any of the quality assurance regulations applicable to other laboratories. Thus, Medicare exempts physicians' office laboratories from these standards. As a result, the expense that attends compliance with these regulations does not apply to physicians' office laboratories, and few barriers to entry exist for physicians wishing to continue earning profits from laboratory testing services. In addition, because of the absence of any quality assurance regulation, these physicians' office laboratories may

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[11/] While this scenario does not result in increased outlays for the Program, it does injure beneficiaries. Thus, if a doctor charges a beneficiary $20.00 for a test that is listed on the fee schedule at $10.00, the beneficiary will only receive $8.00 from the Program and will owe the doctor $12.00.

[12/] Physicians are in a unique position when they perform testing services as they control both demand and supply. The incentives to overutilize are obvious.

perform at substandard levels creating the potential that disease will continue undetected. When illness remains undiagnosed, the costs of treatment, when diagnosis finally occurs, are usually higher than they would have been had the condition been diagnosed earlier.

Thus, ACLA's fourth recommendation is that the United States Congress enact legislation that would require physicians' office laboratories to be certified by the Medicare Program under the same regulations that apply to independent laboratories. Such a measure would assure that Medicare is receiving value for the monies it spends on testing performed in physicians' offices. Enactment of such a proposal would also discourage physicians from starting laboratories if the principal reasons underlying the decision to perform laboratory tests are financial rather than medical.

Finally, ACLA has observed that physicians who do not want to establish laboratories in their own offices but who do wish to profit from laboratory testing have been investing in laboratories (often called "captive laboratories") to receive profit distributions.[13/] In general, these arrangements work as follows. An entrepreneur decides to offer physicians who refer laboratory testing the opportunity to invest in a laboratory. Many physicians are accepting such offers. Then the physician

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[13/] ACLA is prepared to share with the Committee specific information about how these arrangements work and how they are being marketed.

investors refer their testing to the captive laboratory. The captive laboratory in turn distributes profits to the investing physicians. These arrangements cannot help but induce physicians to overutilize testing services as the more the captive laboratory is used the greater the profit to be distributed to the physician investors. A recent May 9, 1984 report issued by Michigan Blue Cross and Blue Shield confirms that physician investment in captive laboratories leads to overutilization. It concludes at p. 1 that "[t]he number of services per patient in the physician-owned lab group is ... 20.97% higher than the average for all labs and ... 39.65% higher than the average for non-physician owned labs." Thus, ACLA's fifth budget savings proposal is that the Medicare Program should disallow reimbursement to any laboratory for testing services performed on specimens sent to that laboratory by a physician-investor.[14/]

ACLA believes that if all five of these recommendations are adopted, the Medicare Program will experience substantial cost savings without the necessity of a fee schedule freeze or ceiling.

[14/] ACLA is not the only voice to express concern about these arrangements. Others include the Federal Bureau of Investigation, Arnold Relman, M.D., Editor of the New England Journal of Medicine, the Michigan Medicaid Program, Region V of the Health Care Financing Administration and the States of New York and Michigan.

III. PROPOSAL TO RECOGNIZE TRIP FEES

Under current Medicare reimbursement policy, laboratories that collect diagnostic specimens from patients who come to the facility for the collection service are entitled to receive a $3.00 specimen collection fee from Medicare. Although ACLA supports this policy, nagging and persistent problems continue in the specimen collection area. Thus, if a laboratory sends phlebotomists to a nursing home or home bound patient, the Program fails to pay for any of the costs associated with the travel. Laboratories should be reimbursed for the services that they provide when they must travel to a nursing home or home bound patient to collect laboratory specimens. These services include both transportation and specimen collection, and separate fees should be recognized for each. The current policy, which only recognizes a specimen collection fee of $5.00 when one patient is drawn or $3.00 when multiple patients are drawn, is inadequate. One ACLA member has calculated that the direct costs of performing a venipuncture on a nursing home patient is $7.50, a figure that includes no overhead allocations. Simply stated, laboratories should be reimbursed more when they employ trained phlebotomists to travel to the patient to collect specimens than these facilities receive when the patient travels to the laboratory for specimen collection.[15/] Under the current reimbursement policy, a laboratory only receives an increased payment if it collects from one nursing home or homebound patient. However, if it collects from multiple nursing home patients, no additional payment is recognized. Obviously a laboratory incurs higher costs when it must travel to the patient than when the patient comes to the laboratory. Thus, this Subcommittee should instruct HCFA to remedy this problem.

In addition, HCFA should be directed to recognize a supplemental fee for special, non-routine house calls to pick up specimens.[16/] Again, a laboratory incurs costs in employing persons to travel to a patient even if that employee does not provide any specific collection service when he arrives at the patient's residence. Failure to recognize the additional costs that a laboratory experiences when it must employ persons to travel to the patient may undercut a laboratory's ability to provide specimen pickup from nursing home and home bound patients.

The provision of care to nursing home and home bound patients is growing rapidly, a phenomenon that has accelerated in

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[15/] Significantly, drawing blood from elderly patients residing in nursing homes is often difficult and time consuming, requiring patient, highly trained phlebotomists. These phlebotomists must often provide services at odd hours of the day and night and be available on call for emergencies.

[16/] By special, non-routine house calls, we are referring to those pickups that are not part of the laboratory's routine courier service.

response to earlier discharges caused by the DRG-based reimbursement system applicable to hospital inpatient services. Thus, ACLA members are experiencing increased requests for nursing home and homebound collection and pickup services. The provision of these services is substantially less expensive for the Program than transporting the patient by ambulance to a hospital for the provision of the services. Therefore, ACLA strongly urges this Committee to approve legislation that would recognize and pay for the increased costs that laboratories incur when they provide specimen pickup and collection services to nursing home and home bound patients. The easiest way to accomplish this goal would be for the Committee to approve legislation directing that the Secretary pay a reasonable trip fee based on mileage.

IV. OPPOSITION TO HCFA PROPOSAL TO EXPERIMENT WITH COMPETITIVE BIDDING

On May 31, 1985, HCFA issued a request for proposal ("RFP") announcing that it intended to initiate a demonstration pursuant to which Medicare testing services in certain geographic sites would be procured via competitive bidding. According to the RFP, hospital laboratories providing testing to nonpatients and independent laboratories would not be eligible to provide covered services unless selected as bid winners. Thus, bid losing or non-bidding laboratories would be excluded from participating in the Medicare program. The principal criterion for selecting bid winners would be price. Reimbursement for hospital outpatient testing and physician's office testing, although available, would be no higher than bid-winning prices. ACLA strongly opposes this demonstration and urges this Subcommittee to direct that the RFP be rescinded.

First, as this Committee well knows and as discussed above, last year Congress replaced Medicare's reasonable charge reimbursement methodology for laboratories with fee schedules, slashing per test laboratory reimbursement by an overall 40% and mandating other significant changes that have substantially disrupted the industry. In the face of the recent and as yet incomplete implementation of fee schedule-based reimbursement, use of competitive bidding, even on an experimental basis, is both premature and ill-advised. Any knowledge gained by a demonstration conducted at this time will have little to no predictive value given the recently modified reimbursement environment. Moreover, substantial cuts in laboratory reimbursement have already been achieved, and additional savings are projected for the future.

Second, when Congress enacted the fee schedule reimbursement methodology, it _sub silentio_ rejected the Administration's proposal, contained in its FY 1984 budget package, that the Secretary be authorized to enter into exclusive arrangements or utilize volume purchasing or competitive bidding mechanisms for obtaining testing services for Medicare beneficiaries. This Committee, like the HCFA laboratory task force,[17] discussed above, obviously concluded that competitive bidding was not an appropriate procurement vehicle and chose the fee schedule approach instead. Now, HCFA seeks to ignore the will of Congress, as expressed in the DRA, and through this competitive bidding "demonstration," deprive beneficiaries of their statutorily-guaranteed right to choose their health service suppliers.

Third, Medicare beneficiaries will be adversely affected as competitive bidding will not only strip them of freedom of choice but will also probably compromise the quality of laboratory testing. Previous governmental use of competitive bidding has resulted in poor laboratory testing and has even caused several deaths.[18/] Medicare beneficiaries may also be deprived of testing services should the bid winner experience an equipment or facility breakdown or be otherwise unable to perform. Furthermore, beneficiaries may be deprived of timely laboratory services and convenient, easily accessible locations for specimen collection, a particular hardship for the elderly. Nor will beneficiaries enjoy any offsetting benefits as they currently have no cost-sharing obligations when their clinical testing needs are fulfilled by an independent or hospital laboratory.

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[17] In its report, the Task Force opted for fee schedule reimbursement rather than competitive bidding and noted that it had a number of reservations about competitive bidding, including: 1) "the disruptive effect that limiting the number of Medicare-participating laboratories could have on the industry as a whole"; 2) the creation of "local monopolies"; 3) the possibility that it could "result in higher costs to Medicare in the long run as fewer laboratories remained in business"; 4) the potential for deterioration in the quality of testing; 5) the probability that "low-ball" bids would be submitted; 6) the potential inability of the Program to interest back-up laboratories in performing at the bid prices in the event that winning laboratories proved unable to deliver the services; 7) the likelihood that "physicians dissatisfied with the service of a winning laboratory or the quality of its results [might] use non-participating laboratories and thus leave the beneficiary totally at risk for the cost of lab tests"; and 8) the creation of numerous administrative problems. pp. 23-24.

Fourth, competitive bidding will impair competition among clinical laboratories, creating long-term injuries to the marketplace. Physicians do not split patronage among several laboratories. Thus, a laboratory bid winner will likely prosper while non-bid winners will lose both Medicare and non-Medicare business, possibly forcing them to sell to bid winners or to go out of business completely. Accordingly, the demonstration will reduce and eliminate competition, resulting in long-term distortion of local market forces -- distortions that will last far beyond the life of the demonstration and that may permanently impair the competitive environment in the region. Moreover, reduction in the number of laboratories available to service Medicare patients may ultimately force the Program to deal with

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[18/] These tragedies are recounted in the task force report at p. 23 and in ACLA statements opposing competitive bidding. ACLA would be pleased to share the information it has on this subject with the Committee.

the few laboratories that remain. Those laboratories may be able to command uncompetitive prices from the Program.

Fifth, the RFP compromises the Administration goal (a goal ACLA shares) of achieving a level playing field on which laboratories compete. Thus, non-winning independent laboratories are excluded from receiving Medicare payments, hospitals may decline to bid and still obtain Medicare reimbursement, and physicians are precluded from bidding but can still provide covered testing services, despite that fact that physicians' office laboratories remain exempt from Medicare's quality assurance standards. This differing treatment discriminates against independent laboratories and represents poor policy.

Sixth, competitive bidding may also cause increased hospitalizations. If a physician cannot obtain prompt specimen collection services or timely test results from a bid-winner, he may opt to hospitalize his patient rather than order the service from the bid-winner.

Seventh, physicians dissatisfied with the bid winner may open their own laboratories or expand the use of their preexisting laboratories. As physicians' office laboratories are exempt from Medicare quality assurance regulation, this response will deprive the Program of any guarantee that the testing is reliable, accurate or precise.

Eighth, the administrative costs of the demonstration will likely be high. These expenses should not be incurred in this era of cost containment, particularly as there can be no assurance that the demonstration will result in reduced Medicare outlays. ACLA has seen no projections on any savings that might result from such a demonstration.

Congress recently instructed Medicare to reimburse laboratories under new methodologies which promise substantial savings to the Program. In light of these changes and the disadvantages of competitive bidding, ACLA strongly urges that this Committee instruct HCFA to rescind the competitive bidding RFP.

V. CONCLUSION

In summary, ACLA opposes proposals to freeze or cap reimbursement pursuant to the fee schedules, particularly in light of HCFA's failure to simplify its billing and collection procedures or promulgate regulations implementing the discretionary portions of the DRA's laboratory payments provisions. Dealing with the Program is expensive. While per test payments to laboratories have been substantially reduced, the costs of doing business with the Program have not. If additional savings are necessary ACLA proposes: 1) reduction of the hospital outpatient fee schedule to 60%; 2) elimination of the 1987 sunsetting provision applicable to hospital outpatient testing; 3) extension of mandatory assignment to physicians who perform or supervise laboratory testing; 4) imposition of quality assurance standards on physicians' office laboratories; and 5) disallowance of reimbursement for testing referred to laboratories by physicians who have invested in such laboratories. In addition, this Committee should direct HCFA to pay trip fees to assure that nursing home and home bound patients continue to receive needed laboratory testing service. Finally, this Committee should direct HCFA to rescind its competitive bidding RFP.

Again, let me thank you for the opportunity to participate in this hearing. ACLA would be pleased to supply this Committee with additional information or respond to questions. Thank you.

STATEMENT OF THOMAS M. ANTONE IV, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS, WASHINGTON, DC

Mr. ANTONE. Thank you, Mr. Chairman. My name is Tom Antone. I am the new president of the National Association of Medical Equipment Suppliers. I am also an impromptu speaker this morning. Our chairman, Mr. Sandy Linden, was unable for medical reasons to travel.

As an impromptu speaker, I may fumble, and I will apologize for that now. As an impromptu speaker, I will probably be brief, and I assume I don't have to apologize for that. [Laughter.]

NAMES is the largest association representing home medical care suppliers. We have about 1,600 members. We serve about 2 million patients a year.

One of the businesses we are in is avoiding institutionalization. We do it through providing durable medical equipment, parenteral and nutritional equipment, oxygen and oxygen services, walkers, wheelchairs, and the like, in the patient's home. We also provide the services that support them.

I have only five points that I want to make this morning, and I would like to make them for brevity's sake in the context of H.R. 3101 and H.R. 3128, which are of course known to the committee here and the committee staff. I think it would facilitate our discussion.

Point one deals with reimbursement limitations. Surprisingly enough, we support limiting reimbursement increases for rented equipment next year. Obviously, we prefer the Ways and Means proposal which would set that limit at 1 percent, rather than the Energy and Commerce that would set it at zero percent, but we could accept a limitation.

We feel that the 1 percent does the obvious, which is to acknowledge that inflation, while much abated, is at least not totally defeated. And 1 percent would help us handle costs that we have incurred, that have increased for us, that we just can't control.

We also join the House committees in believing that reimbursement for purchased equipment should not be arbitrarily limited this year, contrary to the administration's proposed rulemaking of August 16.

The reason for that, and we join the House in their reasoning, is that the purchase concept is so new under the program that inadequate data exist to set prices with any kind of confidence that they are equitable.

Consequently, we respectfully request that this committee reach the same decision that the House committees and the industry have reached, and to not freeze purchase prices this next year.

We do join the House in support of indexing rental allowances through the CPI beginning in fiscal year 1987. However, we would request that purchase allowables not be indexed until fiscal year 1988. The reason for that is the same: Available purchase data are inadequate. There is an additional reason, and that has to do with a statistical quirk in the way that the Health Care Financing Administration updates its prices every year; that is, they run approximately 2 years behind.

The data used for updating reimbursement rates each October are collected from April 1 of the preceding year through March 31 of the current year. The point of that is that rent-purchase was only instituted in February, so you would only have February and March, or 2 months of data, to set prices which would then be indexed in fiscal year 1987 under the House bill.

We believe that is probably inadvertent. They just didn't realize this statistical quirk was in there. We would ask that you delay indexing purchase prices until fiscal year 1988—the beginning of fiscal year 1988, to allow collecting at least a year's worth of purhase data.

Point two is on the subject of mandatory assignment. I regret that we have to oppose it. In a recent sample survey, GAO found that the assignment rate in our industry is 96 percent. So, it isn't broken. Why fix it?

Second, in eliminating voluntary assignment rate data, you are going to take away data which are used by this committee, by the industry, and by the department in overseeing departmental operations for the program.

If you feel that you must go with mandatory assignment, we would ask that you link the effective date to the effective date of regulations, defining "inherently reasonable" as required by the House bills and to the effective date of any judicial appeals process that the committee might see fit to give us, as Energy and Commerce would.

I have mentioned inherently reasonable. The House bills would require the department to define "inherently reasonable" criteria in regulation. We support that. We hope we can convince this committee to also support that.

On the subject of Judicial appeals, Energy and Commerce has acknowledged that appeals don't exist under part B of the program. I think they are also tacitly acknowledging that the department may be in a position from time to time to take advantage of that.

We would hope that you would agree with Energy and Commerce and go along with an appeals provision for us.

Thank you, sir.

The CHAIRMAN. You do very well as an impromptu speaker.

Mr. ANTONE. Thank you.

[The prepared written statement of Mr. Linden follows:]

PREPARD STATEMENT OF SANFORD J. LINDEN, CHAIRMAN OF THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

Thank you, Mr. Chairman, for allowing the National Association of Medical Equipment Suppliers (NAMES) to present it's views regarding the effects of various budget proposals on the Medicare Program. My name is Sanford J. Linden. I am Chairman of NAMES and owner of Linden Home Health Care, Inc., Southfield, Michigan.

NAMES, with a membership of over 1,400, is the largest trade association representing home care medical equipment suppliers throughout the country. Our members serve over 2 million patients who are able to avoid institutionalization because of the availability of medical equipment ranging from walkers and wheelchairs to oxygen-related items to high-tech nutritional therapy. Home care equipment suppliers provide not only the equipment but also the services that are essential to assure proper functioning and use of the equipment in the home. Most NAMES members serve Medicare beneficiaries.

The Administration and the House Committees on Energy and Commerce and Ways and Means each have made public their positions on issues of vital importance to the durable medical equipment (DME) industry. These positions are well-known to the members of this Committee and Committee staff. Thus, I would like to present our view today using the issues as they see them as a framework for my remarks.

Reimbursement Limits

The House committees would limit increases in Medicare reimbursement for medical equipment furnished on a rental basis in FY 1986. Obviously, the industry prefers the Ways and Means proposal permitting a 1% increase. As you know, Energy and Commerce would provide for no increase at all in FY

1986. While Congress and the Administration have done an admirable job in controlling inflation, the fact remains that inflationary increases persist. Under these circumstances, an increase of at least 1% would acknowledge that suppliers' costs have increased due to factors beyond their control.

I also want to recall for this Committee the fact that the House committees were silent regarding reimbursement limits for equipment furnished on a purchase basis in FY 1986. We understand this silence was to recognize the fact the "purchase" is a new concept under Medicare and therefore available purchase charge data are inadequate to justify additional reimbursement limits at this time and that purchase reimbursement should not be arbitrarily limited this year; rather, the historical method of upgrading purchase screens should be followed.

NAMES supports this reasoning, but fears that not expressly addressing this point will encourage HCFA to limit purchase as well as rental reimbursement on the theory that legislative silence means Congress does not care what actions the Department takes regarding purchase prices. This fear is borne out by the fact that subsequent to the drafting of the House bills, HCFA published a Notice of Proposed Rule-making (NPRM) expressing its intent to freeze all DME reimbursement for FY 1986 at FY 1985 levels. (See August 16, 1985 Federal Register at p.3324.) The Department, of course, knows Congress is currently debating this issue, but reasons it can move more rapidly than the Legislative branch.

Under these circumstances, we urge the Finance Committee to incorporate bill and/or report language expressly stating its intent that reimbursement for equipment furnished on a purchase basis in FY 1986 be determined in accordance with prior law and without arbitrary application of inherent reasonableness. NAMES believes this request is consistent not only with the intent underlying limitation of rental prices only, but also with other House proposals which would limit the Secretary's authority to apply "inherently reasonable" in an across-the-board fashion.

The House bills would also cap increases in rental and purchase reasonable charges at the Consumer Price Index (CPI) for FY 1987 and later. NAMES understands the rationale regarding rental reimbursement, but requests the Committee to consider the practical effect of indexing purchase charges as early as FY 1987. In this regard, it is important to remember that FY 1986 charges are set based on data collected between April 1, 1984 and March 31, 1985. Since the purchase concept was only introduced in February of 1985, this means there will only be three months of purchase data underlying FY 1986 purchase allowables which the bills would then index to the CPI in FY 1987. Under these circumstances, NAMES respectfully requests this Committee to delay indexing purchase charges until FY 1988 in order to allow development of an adequate purchase data base before indexing commences. In other areas of the House bills, the Committees adopt this rationale, and we believe omitting it in this context may have been inadvertent.

Energy and Commerce alone would freeze both rental and purchase reimbursement for all oxygen and oxygen-related equipment., As a consumable item, oxygen itself has always been purchased; thus, NAMES agrees ample data on purchase charges are available. However, purchase charges for oxygen-related equipment are by no means well established since the purchase concept is so new. Energy and Commerce seem to acknowledge this fact in freezing reimbursement for DME furnished on a rental basis but not for purchased equipment. Consequently, NAMES requests the Finance Committee to correct this oversight and treat purchases of all equipment in accordance with the general principal that purchase prices for equipment should not be arbitrarily limited in FY 1986.

Mandatory Assignment

Energy and Commerce and Ways and Means both would require mandatory assignment of all DME claims. NAMES understands and supports the Committees' apparent goal of protecting beneficiaries, but requests the Finance Committee to consider the following facts.

GAO reports that the rental assignment rate for DME in the areas they studied is an impressive 96%. Despite the cutbacks and trauma of the past year, there is no evidence the assignment rate has diminished. This suggests that competition—rather than reimbursement levels alone—drives decisions on whether to accept assignment. The DME industry has always been intensely competitive and is becoming more so. Under these circumstances, empirical data simply do not document a need for this provision. If it isn't broken, why fix it?

But there is a more compelling reason for questioning not only the need for, but the wisdom of this provision. Assignment rates are an extremely sensitive measure of the actual effects of decisions implemented by Medicare policy makers. As such, they have always been closely watched by industry and the Department. Under previous Administrations, actual initiatives were launched to increase assignments when rates declined noticeably. We understand Congress also uses this measure in exercising its authority to oversee Medicare operations. Imposition of mandatory assignments is thus not only not necessary given current competitive forces in the industry and a 96% assignment rate, but would eliminate a key indicator currently used to assess program administration in the future.

NAMES urges this Committee to consider the need for and wisdom of imposing mandatory assignment. At the very least we respectfully request that the effective date of mandatory assignment be tied to the effective date of the inherently reasonable regulations which would be required by the House Committee and hopefully this Committee, and the effective date of the changes in Medicare appeal rights contemplated by the Energy and Commerce Committee and, again hopefully, by this Committee. At a minimum, such linkage is necessary to impose some restraint on the Department's demonstrated propensity to act arbitrarily, confident that assignment rate data will not be available to second guess its decisions.

Inherently Reasonable

Ways and Means and Energy and Commerce would wisely place procedural and substantive limits on the Department's ability to utilize "inherently reasonable" in an arbitrary, across-the-board fashion. We earnestly urge this committee to take a similar approach. The Department's August 16, 1985, NPRM freezing all DME reimbursement, and Transmittal 1115 (dated August 1985), confirm the need for this provision to protect both Congressional prerogatives, beneficiaries, and the DME industry. However, both—coupled with earlier Departmental actions affecting DME and physicians alike—also suggest that report language accompanying these provisions should be specific enough to ensure Congressional intent is carried out. NAMES respectfully requests the opportunity to work with Committee staff to develop such language.

Appeal Rights

At present, suppliers and providers under Part B of Medicare have no right to seek any independent review of Departmental decisions affecting the livelihood of the industry and beneficiaries' access to needed services. Energy and Commerce has proposed a modest expansion of appeal rights in certain tightly constrained circumstances. NAMES supports this approach and respectfully urges this Committee to do likewise.

Alternative Reimbursement Methodology Study

GAO's recent final report and continuing problems and increased administrative costs associated with implementation of rent/purchase demand renewed Congressional scrutiny of alternatives to the current reimbursement methodology for DME.

NAMES urges the Committee to require the Department to study and report to Congress regarding such alternatives. In lieu of the Department—whose enthusiasm for performing Congressionally-mandated studies has occasionally been questioned—the Committee might consider requesting ProPAC to conduct such a study.

This concludes my prepared remarks Mr. Chairman. Are there any questions I may try to answer?

Thank you for this opportunity to address the Committee.

The **Chairman**. Gentlemen, I have no questions.

Fortunately, you had your testimony in ahead of time, and I could read it, but I do appreciate your patience this morning in staying here with us as we went through this rather long, long hearing.

We are adjourned.

Mr. **Antone**. Thank you very much.

Mr. **O'Neil**. Thank you.

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

The Honorable Bob Packwood
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Enclosed are responses to questions submitted for the record by Senator Heinz at Secretary Heckler's September 12, 1985, appearance before your committee. We are providing a copy of the responses to Senator Heinz as well.

Please forgive our tardiness in responding and do not hesitate to contact me if we can be of further assistance.

Sincerely,

Patricia Knight

Patricia Knight
Acting Deputy Assistant Secretary
for Legislation (Health)

1. Q. What criteria will be used for selection of the 10 intermediaries to administer the Medicare SNF benefit? It seems in the past that intermediary evaluation and selection has been weighted by such factors as the number of claims denied and the number of dollars not paid out by the Medicare program.

A. Denial rates and dollars denied have never been used by HCFA as criteria for designation of intermediaries. Should the proposed legislation be adopted, the following type of criteria would be used for the selection of the 10 or fewer intermediaries:

- Performance as measured by Contractor Performance Evaluation Program, with particular attention given to those elements specific to skilled nursing facilities;
- Beneficiary service performance;
- Audit and reimbursement program;
- Effective medical/utilization review program;
- The ability to absorb the additional workload, both providers and bills, without a decline in performance;
- An effective provider training and communications program;
- State-of-the-art systems capability with flexibility to accept bills in a variety of telecommunications modes;
- Aggressive electronic media claims marketing; and
- Bill payment unit cost near or below the national average.

Q. What assurances can you give us that factors related to the ability of intermediaries to act in the best interest of the beneficiaries will also be given serious consideration?

A. Extensive evaluation of beneficiary services is included in the Contractor Performance Evaluation Program (CPEP) and will be an integral part of the selection process. Areas evaluated in CPEP include the accuracy and readability of responses to beneficiary inquiries, the timeliness of such responses, whether accurate reconsideration determinations are made, and whether appropriate and readable notices of reconsideration decisions are furnished to all appropriate parties. In addition, contractor toll free telephone service is evaluated for responsiveness to beneficiary inquiries.

Q. Isn't it true that there are tremendous regional differences between decisions made among intermediaries and even differences between decisions made by the same intermediary on identical cases. Isn't it true that even without these differences, recent changes in discharge reviews have led to increased denials in SNF admissions?

A. Medicare regulations and coverage guidelines for skilled nursing facility (SNF) level of care form the decisional framework for all fiscal intermediaries (FIs) when reviewing SNF claims. As a method of providing flexibility for legitimate differences in medical opinion, however, FIs have discretion in rendering individual determinations within the parameters provided by the regulations.

Experience shows that medical practice varies from region to region. The current approach to claims review is more sensitive to variations in local patterns of medical practices and to the availability of different types of services than to stringent national requirements.

Cases reviewed are seldom "identical" because the individual patient's condition and reaction to treatment are unpredictable and variable. Therefore, the decisions made by FIs on such cases may vary from one region to another, one FI to another and even from one reviewer to another within the same FI depending upon the unique circumstances found in the individual medical records.

Although there has been no change in the coverage policies for SNF care, with the implementation of the prospective payment system (PPS) on October 1, 1983, there was a change in the level of review requirement for SNF claims. The FIs were instructed to review all admissions to hospital-based SNFs and 30 percent of all admissions to free-standing SNFs from PPS hospitals to assure that beneficiaries were not prematurely discharged from an acute care hospital. This change in the level of review effort has not resulted in increased denials in SNF admissions. The national denial rate for fiscal years 1982 through 1985 has remained fairly constant:

FY 1982 - 33.5 percent
FY 1983 - 30.6 percent
FY 1984 - 31.9 percent
FY 1985 - 31.1 percent

Q. Also, since home health agencies recently underwent a major change in administration of the benefit to only 10 intermediaries, wouldn't you agree that the waiver of liability should be retained for home health agencies until they have more experience with benefit delivery under these intermediaries?

A. The Department will be taking into account the new configuration for reviewing HHA claims. It will consider what impact this transfer of the HHA claims review responsibilities for freestanding HHAs to ten regional intermediaries will have on HHAs in reaching its decision on the regulation.

2. Q. The original proposed regulation that would have eliminated the waiver of liability on SNFs, home health agencies, and hospitals was pulled pending the conclusions of a HCFA task force that was asked to investigate the issue more thoroughly and reach some conclusions. As I understand it, the conclusions reached by this task force were that while the waiver of liability should be eliminated for hospitals, it should not be eliminated for SNFs and HHAs. Dr. Davis, as I understand it, has acted to implement the task force's recommendations. Why, then, more recently was it decided again that the waiver of liability would be eliminated for all three types of health care providers?

A. The task force was assigned responsibility to explore the background of the issues, to bring together available data, to set forth the options and then to present them for consideration, not to make specific recommendations. At this time the options are still being studied.

Q. On what rationale was the proposed regulation that would eliminate the waiver of liability based?

A. The proposed regulation would not eliminate waiver of liability for providers. It would only eliminate the criteria that, if met, make a provider of part A services eligible for a presumption that it did not know or could not reasonably have been expected to know that the services it furnished would be denied by Medicare as not medically reasonable and necessary or as custodial care. While there would be no automatic payment to facilities with a "favorable presumption" for noncovered care, HCFA would continue to make program payment under the waiver of liability provision based on a case by case analysis of the circumstances to determine whether or not the provider knew or had reason to know of the noncoverage in the particular case.

The proposed regulation reflects the Department's efforts to reduce payments made for noncovered services (that are not medically reasonable and necessary). The recommendation for this proposal was included in a GAO report (GAO-HRD-83-38) which recommended that HCFA establish more stringent requirements for determining waiver of liability for part A providers. It is believed that providers who have participated in the program over a period of years should generally know which services are covered and which are excluded. Use of the presumptive mechanism, established as an administrative device in 1973 when the program was relatively new, is no longer justified.

3. Q. In proposing and implementing the rule that reduced reimbursement to home health agencies as of July 1, 1985, the Department stated its belief that home health agencies are currently operated in a very inefficient manner. What evidence do you have of this inefficiency?

A. o The upper limits on Medicare payment for home health agency (HHA) services that were effective July 1, 1985 do not reduce reimbursement to agencies.

o Since these are upper limits, not rates, and payment is based on the lower of reasonable cost or the limits, the amount of payment for most services delivered by HHAs will be unaffected by these limits.

o The limits are established at 120 percent of mean cost, the most generous level we have ever allowed for mean-based limits.

o The original mean-based percent limits for hosptials and SNFs were established at 115 percent in 1979, and reduced to 112 percent in 1980.

o The SNF limit is now set at 112 percent by statute.

o We did not state that home health agencies are operated in an inefficient manner in the Federal Register notices proposing and implementing the July 1, 1985 limits. Moreover, we specifically recognized the existence of well-managed agencies that are "...able to provide services consistently at a cost below the limits for each service they offer" (50 FR 27737, July 5, 1985).

o However, while almost 65 percent of the 12,142 services offered by the 2,824 HHAs in our data base are provided at a cost below the limit for each service, and over 80 percent of the services have a per visit cost less than $10 above the applicable limits, we encountered a number of agencies with disconcertingly high per visit costs for some services.

o For example, the 82 high per unit costs for skilled nursing that were excluded from the costs used to establish the limits covered a range of $117 to $699. These are the average costs incurred by these HHAs, over an entire year of operation, for a visit that averages less than 1 hour.

o By comparison, the per diem routine service cost limitation for an SNF is approximately $60. This $60 covers the cost of the room, meals, laundry, housekeeping, 24-hour nursing care, and all administrative expenses.

o We believe this is evidence of inefficient operation. Each of the other services in our data base contain per visit costs as extreme as the above example.

4. Q. A provision to freeze durable medical equipment purchase charges was included in the August 16, 1985 HHS proposed rule to limit reimbursement of Medicare nonphysician services. Has HCFA reviewed the current purchase charges that would be frozen to assure that they are (1) statistically valid? (2) the data collected in 1983 to set the current charges is not out-of-date or an erroneous mixture of new and used purchase charges? Has HCFA considered the effect of this regulation on Medicare beneficiaries? Would it be possible for HCFA to submit a carrier by carrier analysis of these points for at least four inexpensive and five expensive items of durable medical equipment?

A. In terms of new DME, we are only applying this regulation, that is freezing and subsequently limiting increases in Medicare reimbursement, to items and services when actual charge data have been used. Therefore, in cases where price lists and other information (other than actual charges) were used to determine Medicare reimbursement, these items and services are not frozen. Each year, Medicare carriers update the customary and prevailing charge screens in order to calculate the Medicare reasonable charge. A part of this update process is to assure that all charges made for items and services are included in the calculation of the charge screen. Other than errors in the calculation, we assume that the charges we receive from suppliers are statistically valid.

The data used to set current charges is based on actual charges submitted for services and items provided during the period April 1, 1984 through March 31, 1985. Also, data on new purchases and used purchases are treated separately. Moreover, according to our instructions, a prevailing or customary charge based on information other than actual charges, such as price lists, is not limited by this regulation.

With regard to the impact of this regulation beneficiaries, HCFA has considered the effect of this regulation on Medicare beneficiaries. In fact, a specific section (D) in the preamble is devoted to the impact on beneficiaries. We have concluded that it will be impossible to fully develop and quantify the impact of changing assignment patterns since it would depend on the future behavior of suppliers; that is, whether they will be motivated to change their billing practices. Nevertheless, we believe that while some suppliers may impose additional charges on beneficiaries, overall, we believe, the restraints on reimbursement will be economically beneficial to patients thru lower coinsurance. While it might, of course, be possible to conduct a carrier by carrier analysis of these issues, we have no plans to do so.

We don't believe that this type of survey will alter our conclusion that nonphysician services, which have been virtually unconstrained since the beginning of the program, should be subject to some limits as to the rate of which reasonable charges will be permitted to increase each year. As our analysis in the preamble to the regulation noted, from 1979 to 1983, these services, as a percentage of the Medicare part B reasonable charge payment, have increased from 6.8 percent to 9.1 percent. In part we attribute this increase to a lack of control or limitations on charges for Medicare part B nonphysician services, supplies and equipment.